

1 34 00 I 0 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 14411 14345 Reg. Dist. No. 1 00 I 0 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 2				d. STREET ADDRESS R.D.# 2			
3. NAME OF DECEASED (Type or print) First GROVER Middle CLEVELAND Last ADKINS				4. DATE OF DEATH Month DEC. Day 16th Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 30, 1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) R.D.# 2 Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Josiah S. Adkins			14. MOTHER'S MAIDEN NAME Mary Frances Calloway				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Clara O. Adkins (Wife) R.D.# 2 Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary occlusion DUE TO (c) coronary arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 18 hours 18 hours 8 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 19 57 to Dec 16, 1958 , that I last saw the deceased alive on Dec 16, 19 58 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Maryland DATE SIGNED Dec. 18th /1958 ACTUAL SIGNATURE L.V. Sohler M.D. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 19, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY			ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE 1 9 '58	24b. REGISTRAR'S SIGNATURE Carlton S. Kinn	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of crematorium		18. Signature of cremation		19. Signature of cremation		20. Signature of cremation	
21. Signature of cremation		22. Signature of cremation		23. Signature of cremation		24. Signature of cremation	
25. Signature of cremation		26. Signature of cremation		27. Signature of cremation		28. Signature of cremation	
29. Signature of cremation		30. Signature of cremation		31. Signature of cremation		32. Signature of cremation	
33. Signature of cremation		34. Signature of cremation		35. Signature of cremation		36. Signature of cremation	
37. Signature of cremation		38. Signature of cremation		39. Signature of cremation		40. Signature of cremation	
41. Signature of cremation		42. Signature of cremation		43. Signature of cremation		44. Signature of cremation	
45. Signature of cremation		46. Signature of cremation		47. Signature of cremation		48. Signature of cremation	
49. Signature of cremation		50. Signature of cremation		51. Signature of cremation		52. Signature of cremation	
53. Signature of cremation		54. Signature of cremation		55. Signature of cremation		56. Signature of cremation	
57. Signature of cremation		58. Signature of cremation		59. Signature of cremation		60. Signature of cremation	
61. Signature of cremation		62. Signature of cremation		63. Signature of cremation		64. Signature of cremation	
65. Signature of cremation		66. Signature of cremation		67. Signature of cremation		68. Signature of cremation	
69. Signature of cremation		70. Signature of cremation		71. Signature of cremation		72. Signature of cremation	
73. Signature of cremation		74. Signature of cremation		75. Signature of cremation		76. Signature of cremation	
77. Signature of cremation		78. Signature of cremation		79. Signature of cremation		80. Signature of cremation	
81. Signature of cremation		82. Signature of cremation		83. Signature of cremation		84. Signature of cremation	
85. Signature of cremation		86. Signature of cremation		87. Signature of cremation		88. Signature of cremation	
89. Signature of cremation		90. Signature of cremation		91. Signature of cremation		92. Signature of cremation	
93. Signature of cremation		94. Signature of cremation		95. Signature of cremation		96. Signature of cremation	
97. Signature of cremation		98. Signature of cremation		99. Signature of cremation		100. Signature of cremation	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14352

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14346

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop 23X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Ronald First Atkins Middle Last		4. DATE OF DEATH 12-9-58 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 22, 1943 15 yrs.
9. AGE (In years last birthday) 15		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Milford, Del.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas S. Atkins		14. MOTHER'S MAIDEN NAME Madge Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Thomas S Atkins - Bishop, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to shotgun wound of face and neck. 9190 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9190 (c) and neck.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot self in face while hunting.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 4:45 a.m. 12-9-58		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Yard of house. Bishop Worcester Md.	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-11-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/13/58	22c. NAME OF CEMETERY OR CREMATORY Evergreen	22d. LOCATION (City, town, or county) (State) Berlin Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry N. Watson - Pocomoke City, Md.		24a. REC'D BY REGISTRAR DEC 15 58	
24b. REGISTRAR'S SIGNATURE Arthur S. K...			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, mostly illegible text and markings on a medical certificate form, including fields for patient information, cause of death, and examiner details.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14347

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYL AND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b 4 Month		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Steward Darnell Banks		4. DATE OF DEATH Month 12- Day 12- Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/58
9. AGE (In years last birthday) yrs. 4		10. IF UNDER 1 YEAR Months 4 Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A.	
13. FATHER'S NAME Robert Bank		14. MOTHER'S MAIDEN NAME Eva Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Eva Bank Salisbury Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interstitial pneumonia 525x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12-13-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/13/58	22c. NAME OF CEMETERY OR CREMATORY GREEN ACERS	22d. LOCATION (City, town, or county) (State) SALISBURY MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR. PRINCESS ANNE, MD		24a. REC'D BY REGISTRAR DATE DEC 17 '58	
		24b. REGISTRAR'S SIGNATURE Charles L. Thoma	

2082213XV5

STATE OF TEXAS
COUNTY OF DALLAS
1913

RECEIVED
JAN 10 1913

STATE OF TEXAS
COUNTY OF DALLAS
1913

THE STATE OF TEXAS,
COUNTY OF DALLAS,
do hereby certify that
the within and foregoing
is a true and correct
copy of the original
as the same appears
from the records of
the County Clerk of
DALLAS COUNTY, TEXAS,
this 10th day of January,
1913.

CLERK OF COUNTY

RECORDED
JAN 10 1913

14354

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 511 Hammond St		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
f. STREET ADDRESS 511 Hammond St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BENNIE Middle ARCHIBALD Last BOZMAN		4. DATE OF DEATH Month DECEMBER Day 8th Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1898
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter -Construction		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Walter James Bozman		14. MOTHER'S MAIDEN NAME Emma Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. Bennie A. Bosman - Mr. Stanley Bozman (Sons) Mrs. Mildred E. Bozman (Wife) 511 Hammond St	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, essential DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		19b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
20. I certify that I attended the deceased from 1956 to 1958 , that I last saw the deceased alive on 12/18 , 1958 , and that death occurred at 6:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE L.V. Sohler M.D.		ADDRESS (Street, city or town, state) Delmar, Maryland DATE SIGNED Dec. 8 / 1958	
21a. BURIAL, CREMATION, REMOVAL (Specify) Burial		21b. DATE THEREOF Dec. 11, 1958	
21c. NAME OF CEMETERY OR CREMATORY Mt Olive Church Cemetery - Revells Neck - Somerset Co		21d. LOCATION (City, town, or county) (State) Maryland	
22. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		23a. REC'D BY REGISTRAR DATEC 9 '58	
23b. REGISTRAR'S SIGNATURE Carroll Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Age of Deceased _____		Sex of Deceased _____	
Usual Residence _____		Date of Birth _____	
Cause of Death _____		Place of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Certificate _____		Office of Registrar _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14355

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14349

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			d. STREET ADDRESS <u>410 Stewarts Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Wallace W Brewington</u>			4. DATE OF DEATH Month <u>12</u> Day <u>10</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-1903</u>		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Purnell</u>			14. MOTHER'S MAIDEN NAME <u>Alice Brewington</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-8764</u>		17. DECEASED'S ADDRESS <u>Mrs. Edna Brewington, 410 Stewarts Place, Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenacre Memorial Park</u>	
22d. LOCATION (City, town, or county) <u>Salisbury</u>		(State) <u>Wicomico Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>Funeral Home, Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifton L. Hanna</u>	

NO. 1000
FEB 19 1941

THE NATIONAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

WASHINGTON, D. C.
20535

REPORT OF THE MEDICAL EXAMINER
ON THE DEATH OF

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF DEATH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF MEDICAL EXAMINER: _____
TITLE OF MEDICAL EXAMINER: _____
OFFICE OF MEDICAL EXAMINER: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14356

CERTIFICATE OF DEATH

14350

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marydel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dear's Head State Hospital</u>				d. STREET ADDRESS <u>RFD # 1, Box 59</u>			
3. NAME OF DECEASED (Type or print) First <u>Beverly</u> Middle <u>Waugh</u> Last <u>Brittain</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 11, 1898</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RE + Unk. ...</u>			
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>George Brittain</u>				14. MOTHER'S MAIDEN NAME <u>Campbell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Unk.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Hospital Records - Salisbury, Maryland</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u>							
DUE TO (b) <u> </u>							
DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>10/20/</u> 19 <u>58</u> , to <u>12/13</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12/13</u> 19 <u>58</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. V. Maldve</u>				DATE SIGNED <u>12/13/58</u>			
PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M.D.</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried Dec 17, 58 ...</u>				22b. DATE THEREOF <u>Dec 17, 58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Lawrence ...</u>				22d. LOCATION (City, town, or county) <u> </u> (State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u> </u> ADDRESS <u> </u>				24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14351

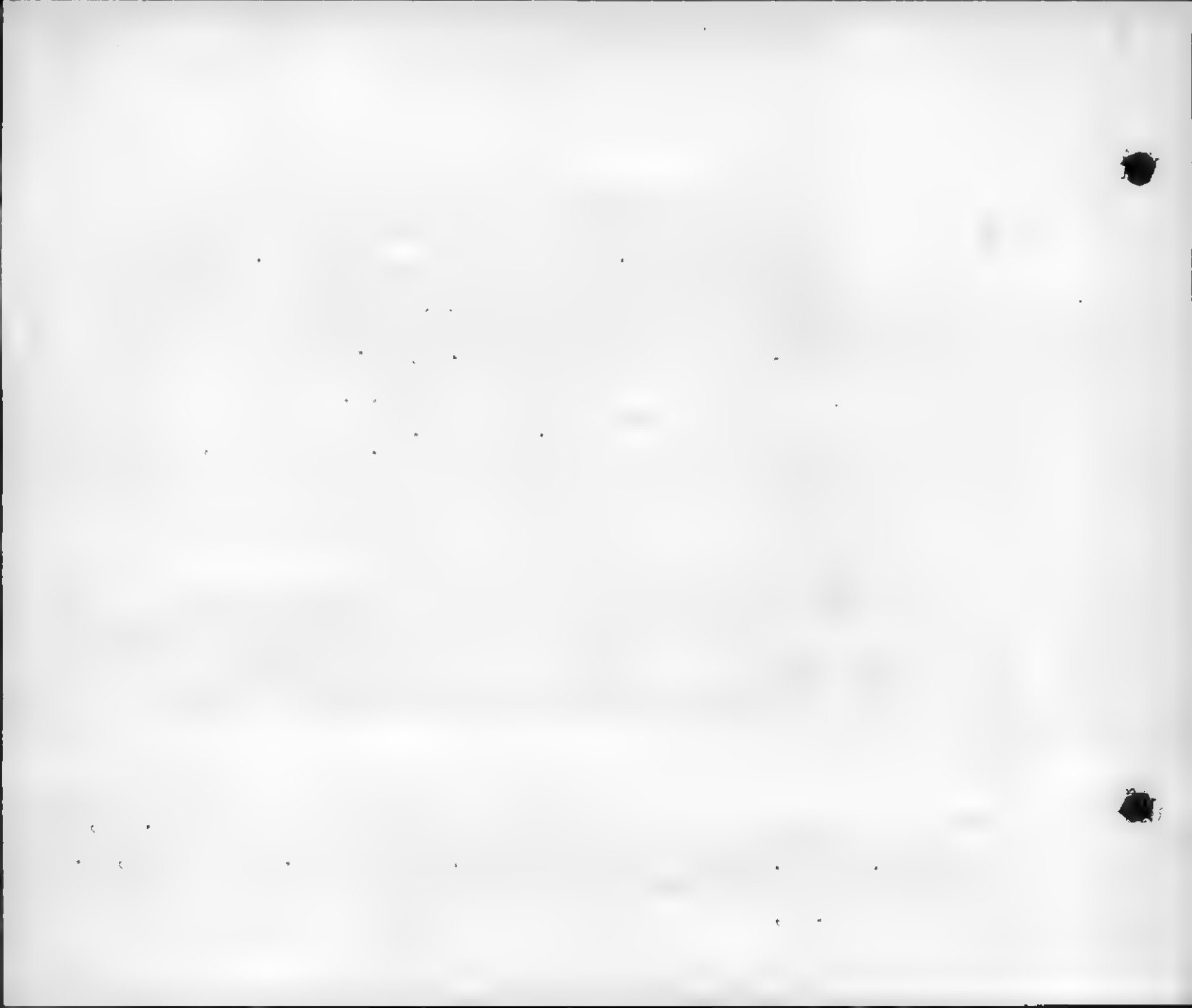
14357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived) II institution Residence before admission) a. STATE Maryland b. COUNTY wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA First J. BRITTINGHAM Middle Lost		4. DATE OF DEATH DEC. 18th 19 58 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1878
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME John Merrill Parsons		14. MOTHER'S MAIDEN NAME Margaret L.W. Brittingham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Albert H. Brittingham (Son) 508 South Division St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized Atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1949 to 12/19 , 19 58 , that I last saw the deceased alive on 12/19 , 19 58 , and that death occurred at 7:25 P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED Dec. 20, 1958			
ACTUAL SIGNATURE F. R. Gramse		M.D. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse		402 S. Division St. Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 21, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DEC 23 '58		24b. REGISTRAR'S SIGNATURE C. L. H. H. H.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



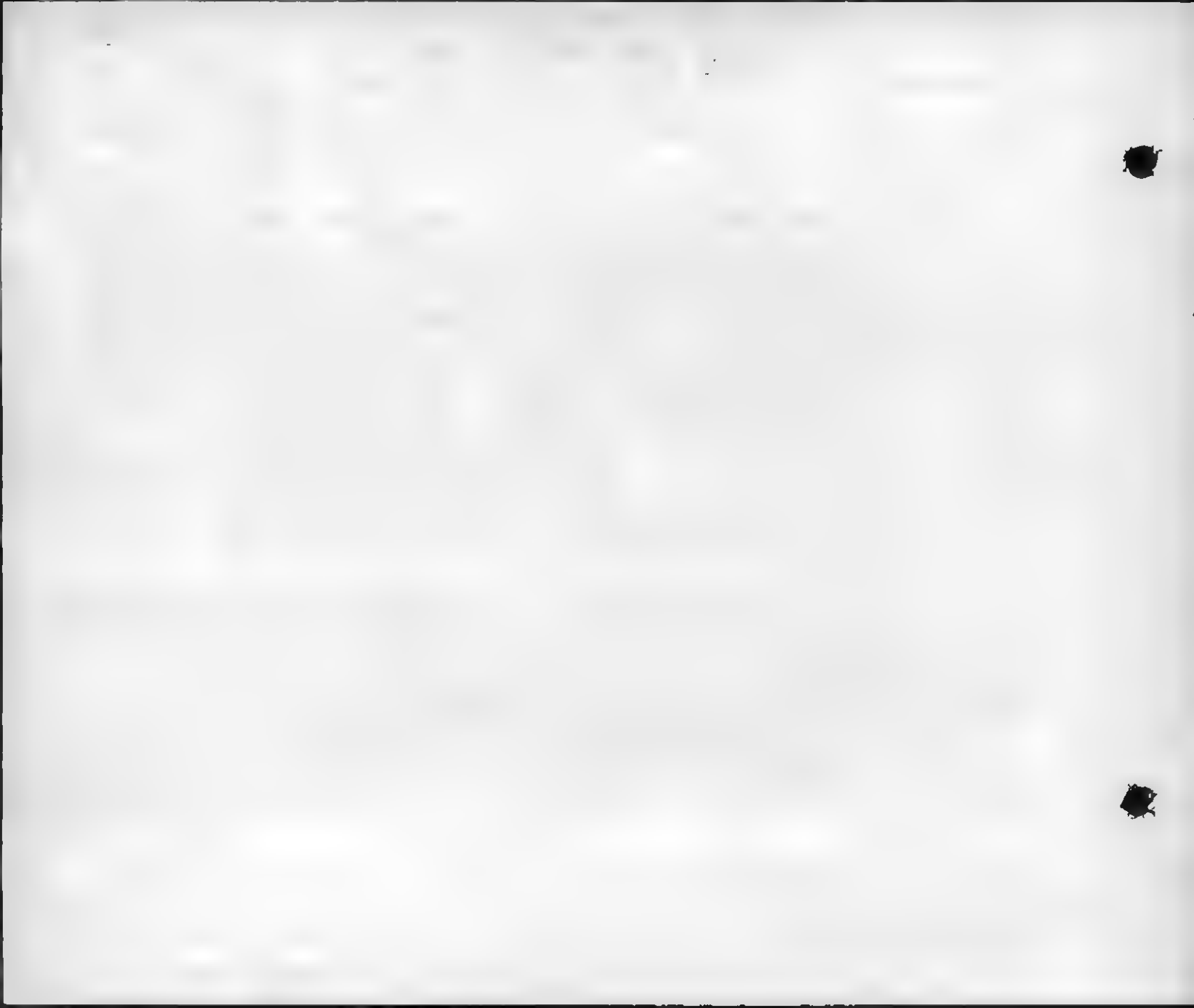
14358 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BISHOP</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>228</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH LELAND BRITTINGHAM</u>				4. DATE OF DEATH Month Day Year <u>DECEMBER 10 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 4, 1882</u>		9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>NORTH R. BRITTINGHAM</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE TIMMONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MRS. J. L. BRITTINGHAM SHOWELL MD</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF LARYNX</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u> <u>9 MONTHS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-24</u> , 19 <u>58</u> , to <u>12-10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-10</u> , 19 <u>58</u> , and that death occurred at <u>12:28</u> A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John M. Bloxom Jr.</u> M.D. <u>Medical Center, Salisbury, Md</u> <u>12-10-58</u> PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM JR.</u> MEDICAL CENTER, SALISBURY, MD <u>12-10-1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Anne A. Burbage</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 15 58</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14353

14359

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>md</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lela</i> First <i>Winston</i> Middle <i>Brown</i> Last <i>Brown</i>		DATE OF DEATH <i>12-4-1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1909</i>
9. AGE (In years last birthday) <i>49</i> yrs.		10. IF UNDER 1 YEAR: Months <i>2</i> Days <i>4</i> Hours <i>2</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>VA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-12-3415</i>	
17. INFORMANT <i>Howard Savage</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Indef.</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year. Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 1958</i> to <i>4 Dec 1958</i> , that I last saw the deceased alive on <i>Dec 1958</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. A. Purnell</i>		DATE SIGNED <i>AD 7 Dec 58</i>	
PHYSICIAN'S NAME (Type) <i>E. A. Purnell, M.D.</i>		ADDRESS (Street, city or town, state) <i>652 W. Main St., Salisbury, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>12-8-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Green</i>	22d. LOCATION (City, town, or county) (State) <i>Salisbury Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dorothy M. Cook</i>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>DEC 10 58</i>			



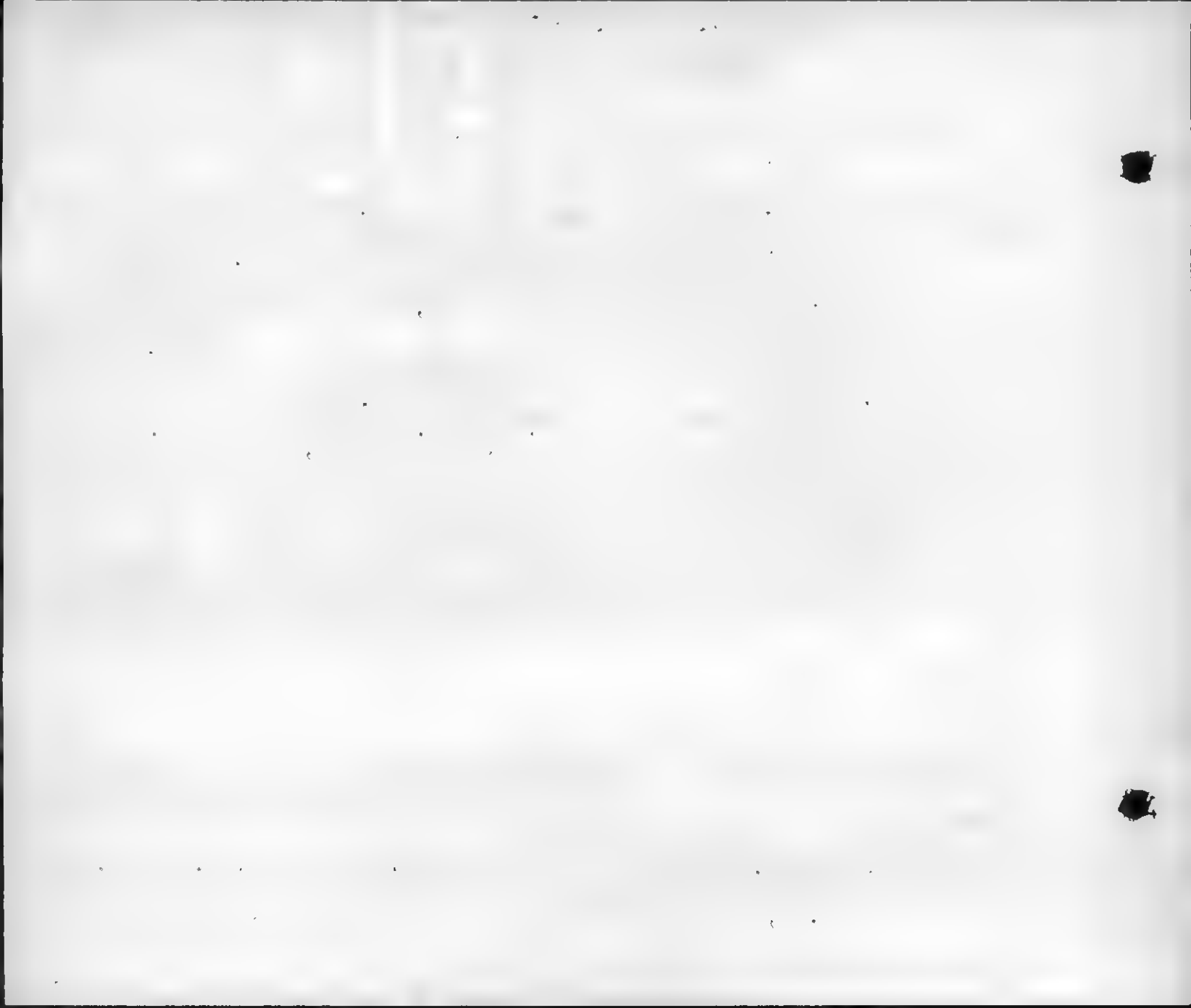
14360

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital		e. STREET ADDRESS 605 N. Division St	
3. NAME OF DECEASED (Type or print) ROBERT HENRY BUNTING		4. DATE OF DEATH Month DEC. Day 23rd Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1888
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Gagsboro, Delaware	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Robert H. Bunting		14. MOTHER'S MAIDEN NAME Margaret E. Hudson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-30 , 19 57 , to 12-23 , 19 58 , that I last saw the deceased alive on 12-22 , 19 58 , and that death occurred at 7:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Camden Ave. Salisbury, Md. Dec. 26/58			
ACTUAL SIGNATURE Earl L. Royer		M. D.	
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		Camden Ave. Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 27, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DEC 31 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14412

CERTIFICATE OF DEATH

Reg. Dist. No.

14355

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 50 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 State St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Salona Middle May Last Callaway				4. DATE OF DEATH Month Dec. Day 7 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 20, 1870	
9. AGE (In years last birthday) 88 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Sussex County, Del.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David Hudson		14. MOTHER'S MAIDEN NAME Louisa Gordy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO None		17. INFORMANT Walter Callaway, Delmar, Del.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Abdominal Aortic Aneurysm DUE TO 451X Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO 16 yrs (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 5 hrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 19 56 to Dec 7 19 58 , that I last saw the deceased alive on Dec 6 19 58 , and that death occurred at 5:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. H. Lynch				M.D. Delmar Del DATE SIGNED 12-9-58			
PHYSICIAN'S NAME (Type) S. H. Lynch				ADDRESS (Street, city or town, state) Delmar Del			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) Delmar, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Gannell Co. Delmar, Del.				24a. REC'D BY REGISTRAR DATE DEC 10 1958		24b. REGISTRAR'S SIGNATURE W. S. Gannell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14361 CERTIFICATE OF DEATH

14356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anna Maria Medical Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23X-2</u> d. STREET ADDRESS • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles E. Carey</u>			4. DATE OF DEATH Month Day Year <u>December 7 1958</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>12-25-1892</u>		9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>			
14. MOTHER'S MAIDEN NAME <u>Mabilia Ann Dickerson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>Wm. F. Davis - Berlin, Md. Rt #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> DUE TO <u>422.01</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C-v disease & stroke</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:24 AM</u> , from the causes and on the date stated above					
ACTUAL SIGNATURE <u>William H. Fisher, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>William H. Fisher, Jr.</u>		<u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-11-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAMILY CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>BERLIN, Md</u>		24a. REC'D BY REGISTRAR <u>DEC 15 '58</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14362

CERTIFICATE OF DEATH

14357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Res dence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester-town 14X-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Fairlee, R.D. 2	
3. NAME OF DECEASED (Type or print) First Rosa Middle Belle Last Carter		4. DATE OF DEATH Month December Day 16 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1877
9. AGE (In years last birthday) 81 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Marydel, Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME David H. Webster	
14. MOTHER'S MAIDEN NAME Ella Nora Urry		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Unk none	
16. SOCIAL SECURITY NO. -		17. INFORMANT Hospital Records, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, general 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 1rs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County) (State)	
21. I certify that I attended the deceased from Sept. 24, 19 58 to Dec. 16, 19 58 , that I last saw the deceased alive on Dec. 16, 19 58 , and that death occurred at 4:50A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/16/58 ACTUAL SIGNATURE L. V. Maldve M.D. Deer's Head State Hospital PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/19/58	22c. NAME OF CEMETERY OR CREMATORY St. Paul Cem.	22d. LOCATION (City, town, or county) (State) Chester-town, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells		24a. REC'D BY REGISTRAR DEC 19 58	24b. REGISTRAR'S SIGNATURE W. L. Wells

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14358

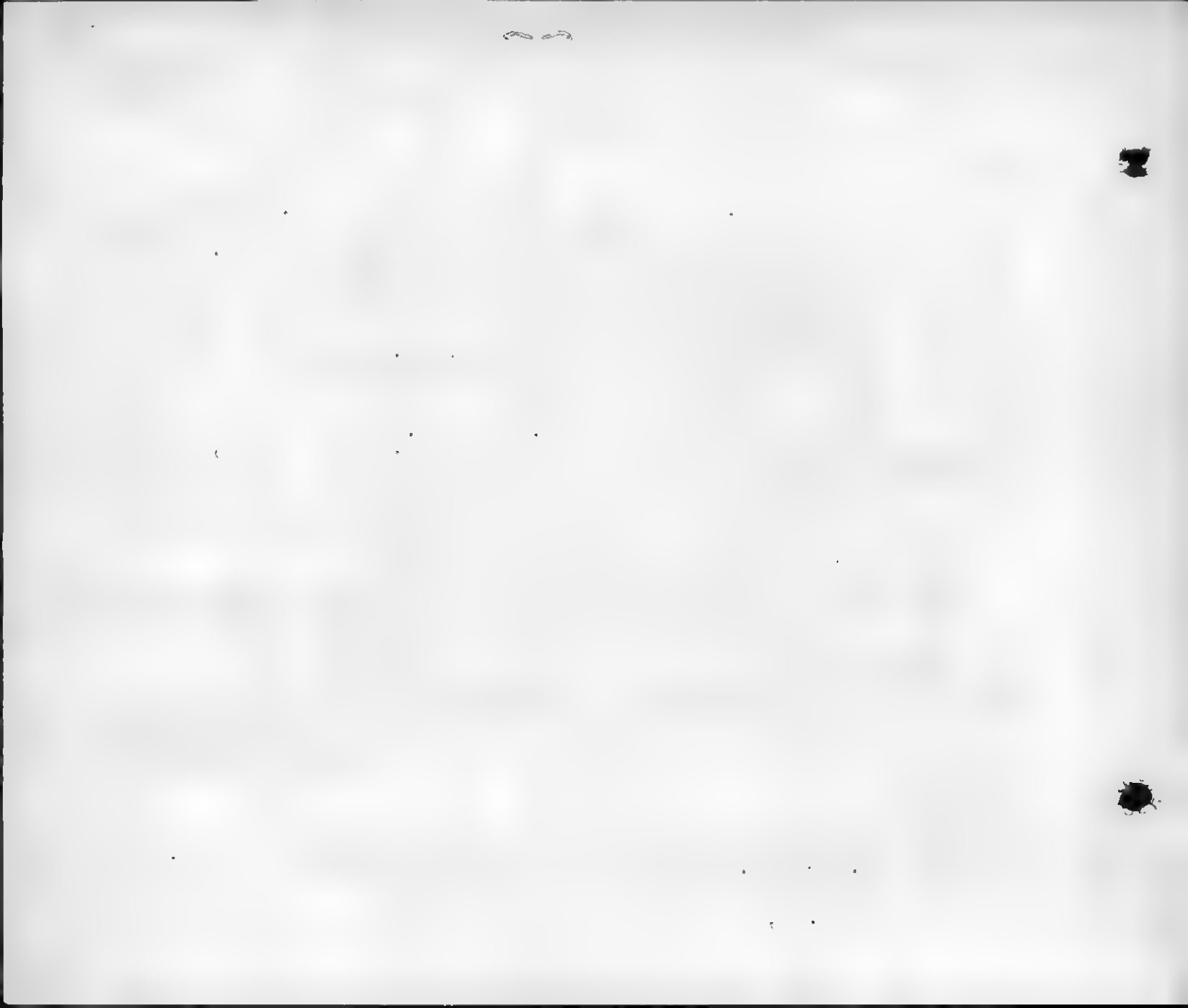
14413

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Salisbury c. LENGTH OF STAY IN 1b Sheldon Ave. Box#180		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sheldon Ave. Box#180 e. STREET ADDRESS Sheldon Ave. Box#180 f. IS DEPENDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RUTH VIRGINIA COFFIN		4. DATE OF DEATH DEC. 8th 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30-1909 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY Wico. Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hayman		14. MOTHER'S MAIDEN NAME Nora Ruark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Samuel J. Coffin (Husband) Box#180 Sheldon Ave. Salisbury, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Sudden (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Earl L. Royer		DATE SIGNED Dec. 8 /1958	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 10, 1958	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DEC 9 '58		24b. REGISTRAR'S SIGNATURE MA	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14363 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>19x</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Princess Anne Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First Middle Last				4. DATE OF DEATH <u>December 17</u> 19 <u>58</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/21/1891</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cook</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13. FATHER'S NAME <u>GEORGE SHAPEL</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>HANDY COLLIER PRINCESS ANNE, MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (d) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Heart Failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>12/15</u> 19 <u>58</u> to <u>12/17</u> 19 <u>58</u> , that I last saw the deceased alive on <u>12/16</u> 19 <u>58</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. H. Jr. MD</u>				ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>12/17/58</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Cottage Grove Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR PRINCESS ANNE, MD</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DEC 22 '58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

14414 CERTIFICATE OF DEATH

Reg. Dist. No.

14360

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 76</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Moses Westly Conway</u>				4. DATE OF DEATH Month Day Year <u>12 4 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1894</u>	9. AGE (In years last birthday) yrs. <u>64</u>	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer (lodger)</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Benjamin Conway</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>Yes WWI</u>				16. SOCIAL SECURITY NO. <u>213-01-1671</u>			
17. INFORMANT <u>Ruth Conway, Tyaskin Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>5 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/19</u> , 19 <u>50</u> to <u>12/4</u> , 19 <u>58</u> that I last saw the deceased alive on <u>12/4</u> , 19 <u>58</u> , and that death occurred at <u>9:30 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Nanticoke Md.</u> <u>12/5/58</u> ACTUAL SIGNATURE <u>Richard H Saunders M.D.</u> PHYSICIAN'S NAME (Type) <u>RICHARD H SAUNDERS M.D. NANTICOKE Md.</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Community Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Tyaskin Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Ashill, Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



14364

Item 7 filed 12-27-58 et

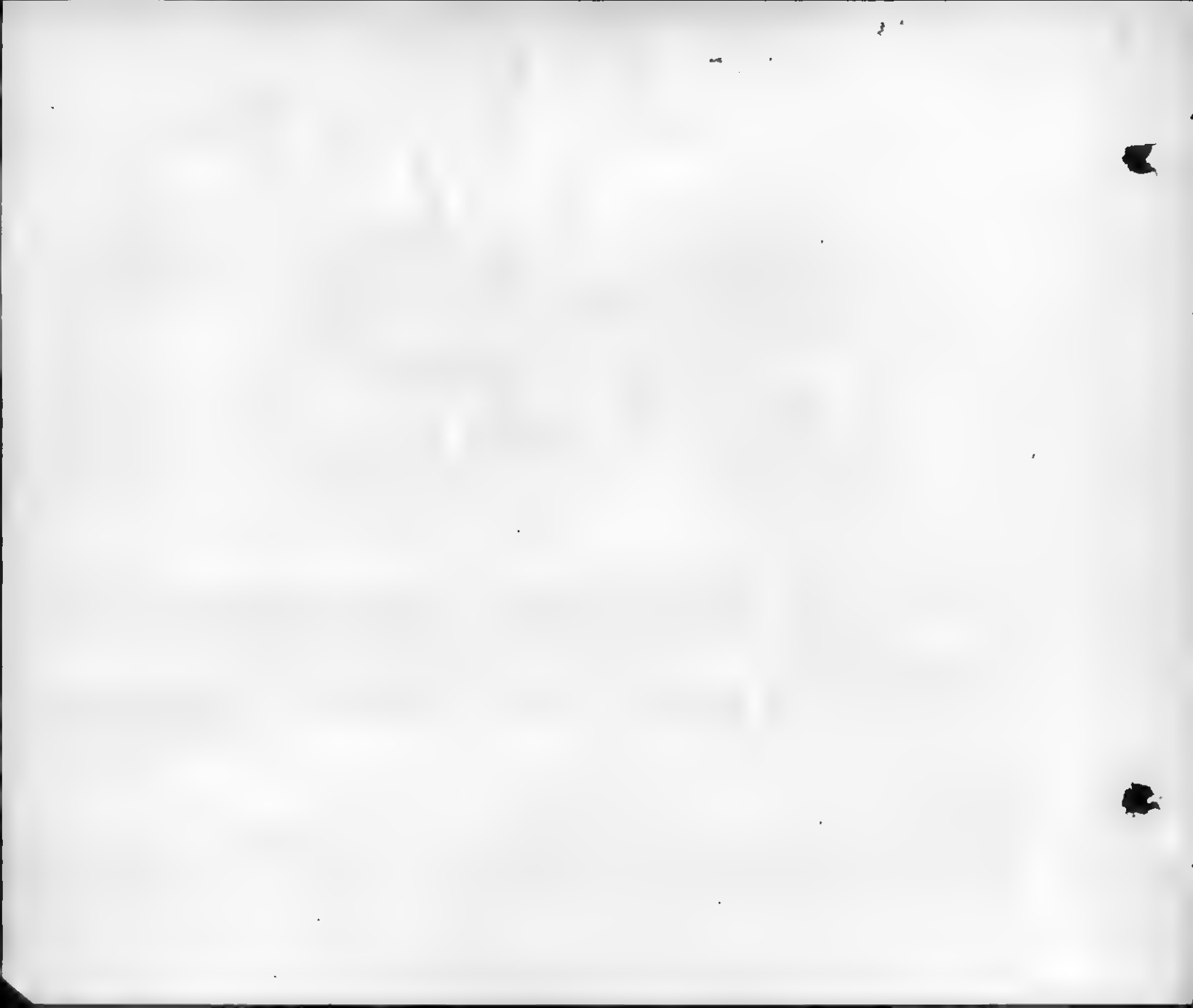
CERTIFICATE OF DEATH

14361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Council</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Cordrey</u> Middle <u>Cordrey</u> Last		4. DATE OF DEATH <u>December 20</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Cordrey</u>		14. MOTHER'S MAIDEN NAME <u>Adeline Hitchers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Ruth Cordrey Delmar Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic pyelonephritis chronic</u> <u>DOAX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholelithiasis pancreatitis</u> DUE TO (c) <u>Hypertrophy of pyloric obstruction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>1 yr</u> <u>3 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Fisher Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>12-20-58</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-23-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nelson</u>	22d. LOCATION (City, town, or county) (State) <u>Delmar Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marshall Co - Delmar Md</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. S. Marshall</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

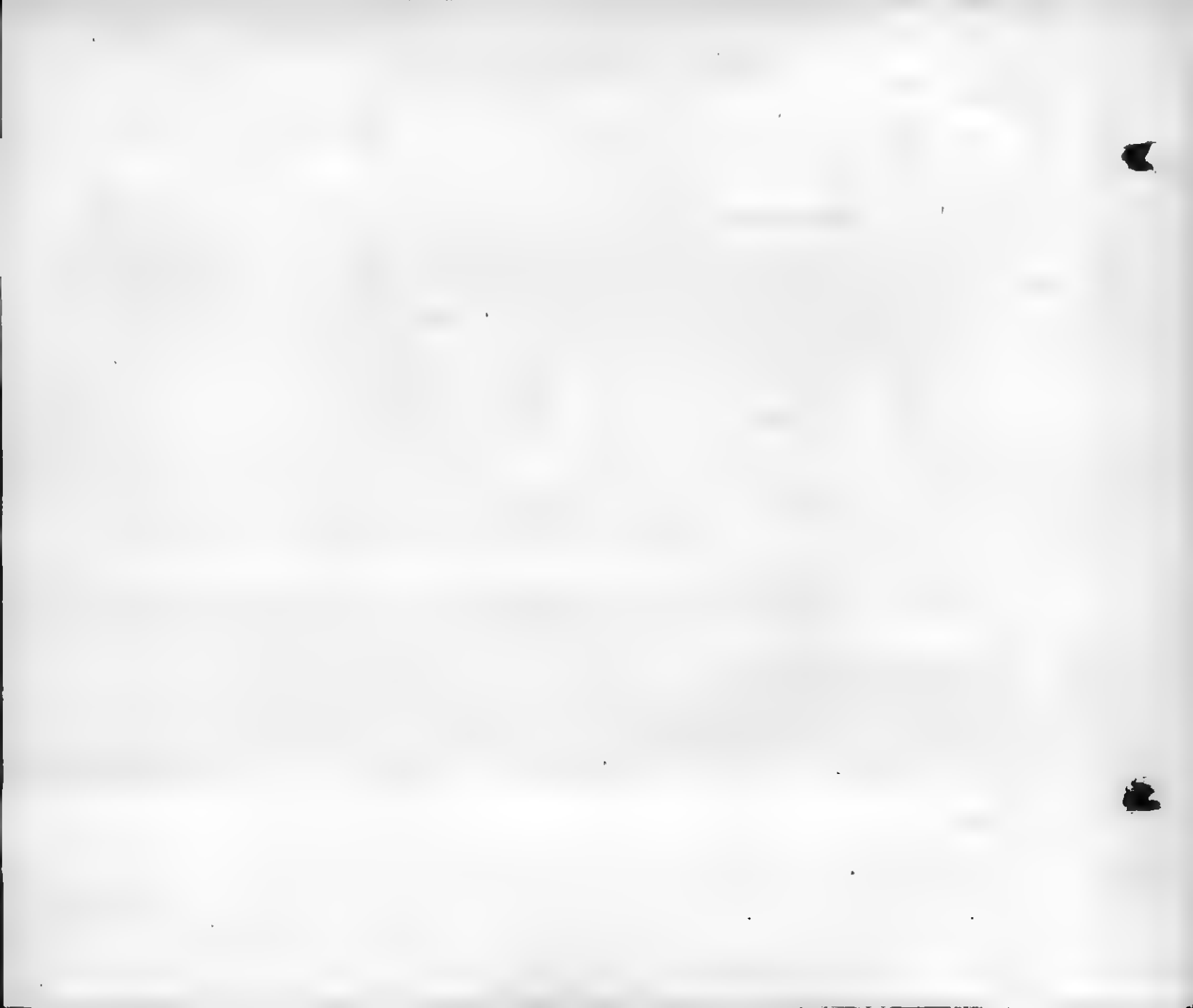
14362

14365

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
c. LENGTH OF STAY IN 1b 104 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Henry Deedon		4. DATE OF DEATH Month Day Year December 8 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1911
9. AGE (In years last birthday) 47 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Deedon		14. MOTHER'S MAIDEN NAME Loleta Coaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. 218-05-6989	
17. INFORMANT Hospital Records, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized sarcomatosis 1972 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcoma, multiple DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 26 , 19 58 , to Dec. 8 , 19 58 , that I last saw the deceased alive on Dec. 8 , 19 58 , and that death occurred at 3:45 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 12/8/58			
ACTUAL SIGNATURE L. V. Maldve, M. D.		PHYSICIAN'S NAME (Type) Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 10 - 58	
22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) Centreville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Edward B. Borton, Jr.		ADDRESS Centreville, Md	
24a. REC'D BY REGISTRAR DEC 15 '58		24b. REGISTRAR'S SIGNATURE C. J. ...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

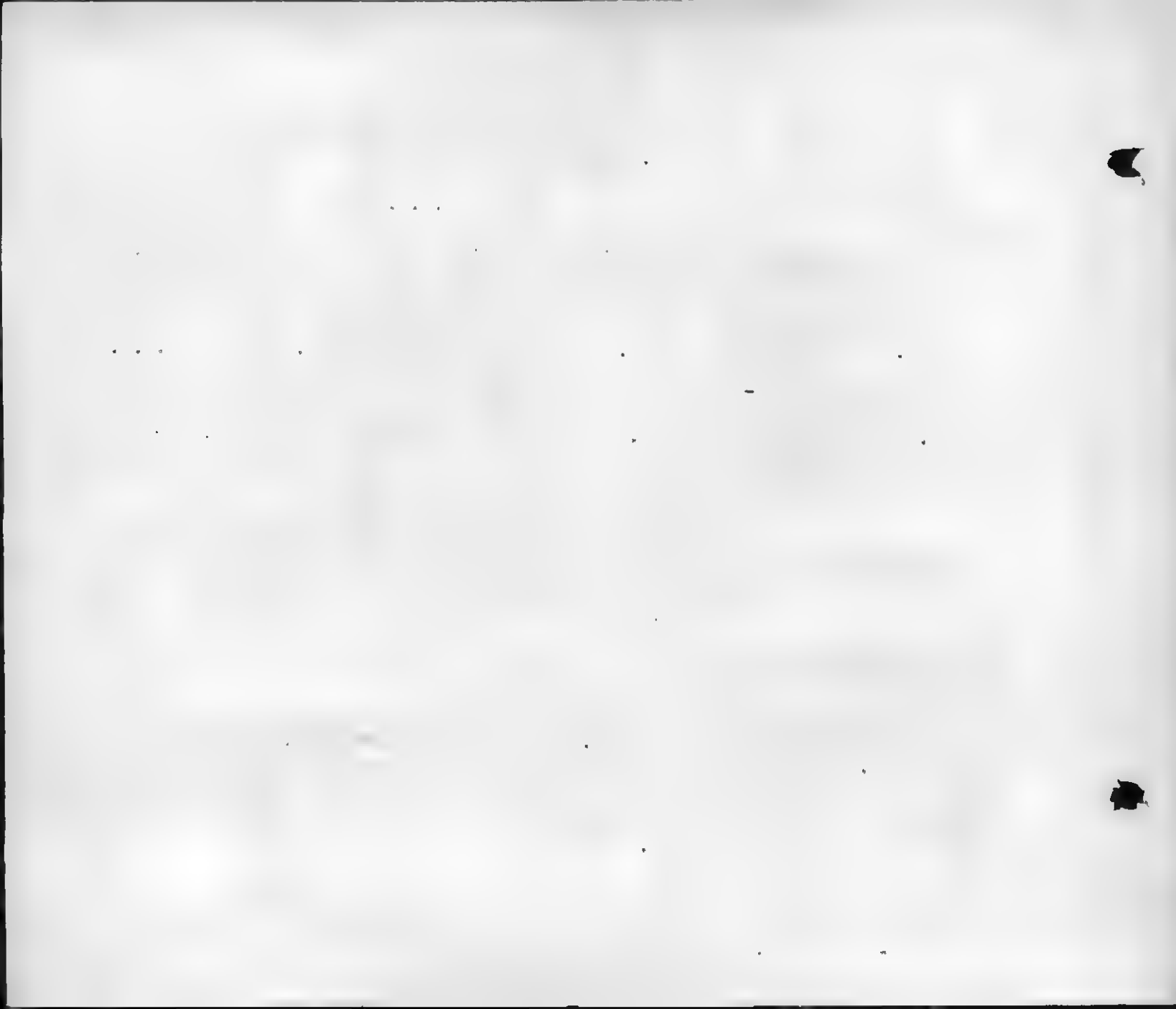
14366

CERTIFICATE OF DEATH

14363

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS R.F.D. #1, Box 179	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Samuel Middle Henry Last Doane		4. DATE OF DEATH Month December Day 25 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1884
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Princess Anne, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Henry Doane		14. MOTHER'S MAIDEN NAME Hargis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO Unk.	
17. INFORMANT Hospital Records - Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Residual left hemiplegy due to cerebral hemorrhage DUE TO (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubiti			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 15, 1958 to December 25, 1958 , that I last saw the deceased alive on Dec. 25, 1958 , and that death occurred at 8:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Vernerman, M.D.		DATE SIGNED Dec. 26, 1958	
PHYSICIAN'S NAME (Type) Verner Juerman, M. D.		ADDRESS Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/58	
22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Cottage Grove, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James Jr.		24a. REC'D BY REGISTRAR DEC 30 58	
ADDRESS Princess Anne, Maryland		24b. REGISTRAR'S SIGNATURE W. H. James Jr.	



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14364

14367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Pen. Gen. Hospital			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsbury (rural) d. STREET ADDRESS P.O.B# 21		
3. NAME OF DECEASED (Type or print) WILLIAM HENRY DONOWAY			4. DATE OF DEATH Month DEC. Day 2nd Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1914		9. AGE (In years last birthday) 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer		10b. KIND OF BUSINESS OR INDUSTRY Junk		11. BIRTHPLACE (State or foreign country) Whaleyville, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A			13. FATHER'S NAME George Benjamin Donoway		
14. MOTHER'S MAIDEN NAME Ella Niblett			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES W.W. #11		
16. SOCIAL SECURITY NO. W.W. #11			17. INFORMANT Mrs. Emma L. Donoway (Wife) P.O.B.# 21 Parsonsbury, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral circulatory failure DUE TO 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intra-abdominal hemorrhage in retro-peritoneum DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Driver of truck that ran off road and overturned.					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of truck that ran off road and overturned.			
20c. TIME OF INJURY Month, Day, Year Hour, a. m. 5:45 P.M. 12-2-58		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Shavox Rd. Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Dec. 4 /1958			
EXAMINER'S NAME (Type) Dr. Earl L. Royer		22a. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery			
22b. DATE THEREOF Burial- Dec. 7- 1958		22c. LOCATION (City, town, or county) (State) R.D.# 2 Snow Hill, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE A. L. S. Huns	
24a. REC'D BY REGISTRAR DEC 8 '58					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14368

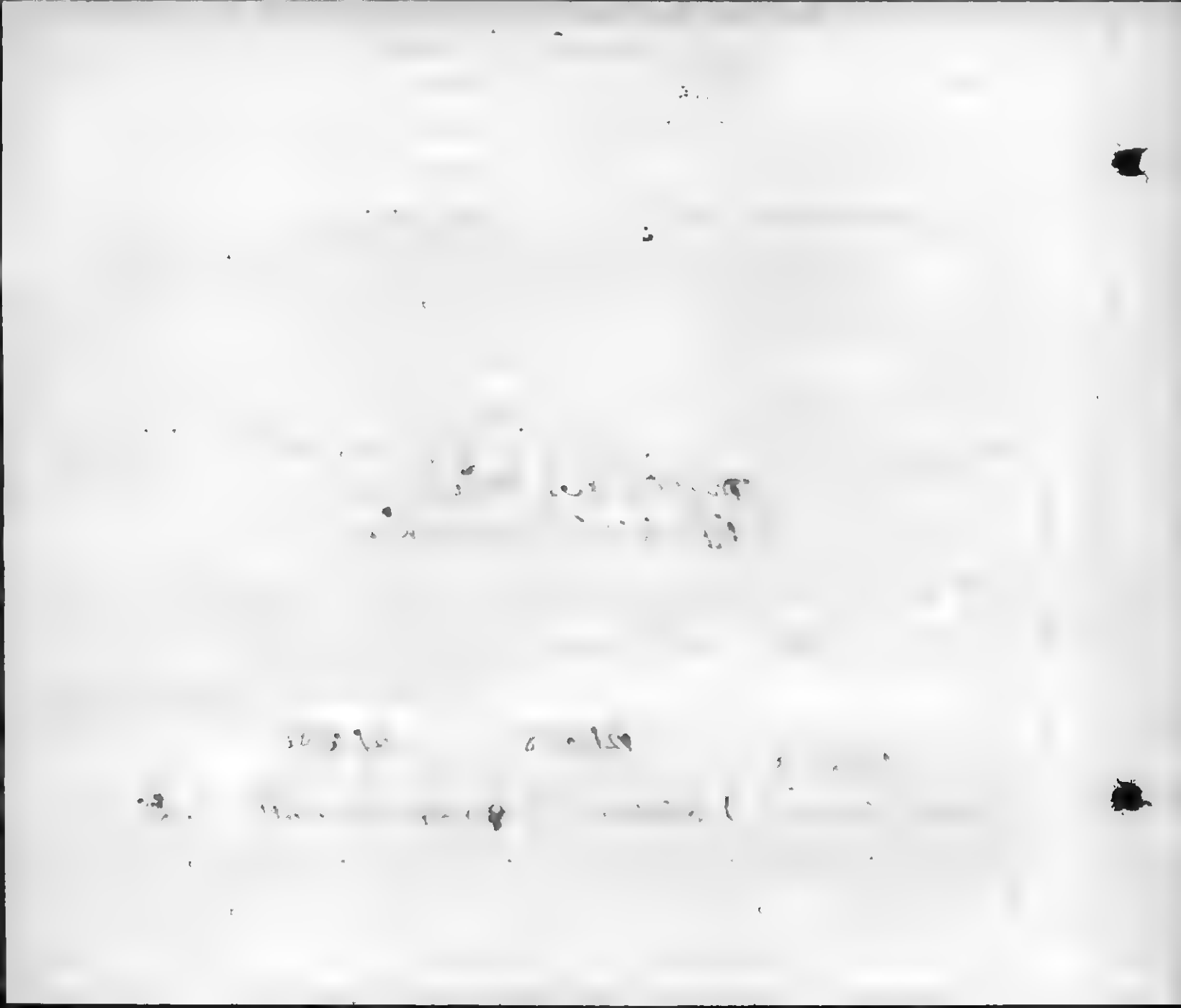
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions Res dence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				d. STREET ADDRESS R.D.# 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGIE Middle LEE Last EFFORD				4. DATE OF DEATH Month DEC. Day 18th Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1869		9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months 9 Days 4	IF UNDER 24 HRS Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Nickolas Moore				14. MOTHER'S MAIDEN NAME Nellie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Amanda Arvey (Daughter) R.D.# 2 Parsonsburg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Double Pneumonia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		
			(State)				
21. I certify that I attended the deceased from 12/16/58 , 19____, to 12/18/58 , 19____, that I last saw the deceased alive on 12/15/58 , 19____, and that death occurred at 10:45 P. M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Carrie I. Hearn M.D. W. N. Hearn				Dec. 20 1958			
PHYSICIAN'S NAME (Type) Dr. Carrie I. Hearn				N. Division St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLL WAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DEC 23 '58	
				24b. REGISTRAR'S SIGNATURE W. N. Hearn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14369

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle BELL Last ELLIS		4. DATE OF DEATH Month DEC. Day 26th Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1890
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 8 Days 8	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) R.D. Salisbury (Wicomico) Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Dykes		14. MOTHER'S MAIDEN NAME Matilda Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Edith Hubeny (Daughter)		Address 1109 N. Div. St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease, severe (c) 			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 2-3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 21, 1958 to Dec 26, 1958 , that I last saw the deceased alive on Dec 26, 1958 , and that death occurred at 5:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alberta Mattax M D		DATE SIGNED Dec. 29, 1958	
NAME (Type) Dr. Alberta Mattax		ADDRESS (Street, city or town, state) 711 Camden Ave. Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 29, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DEC 31 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

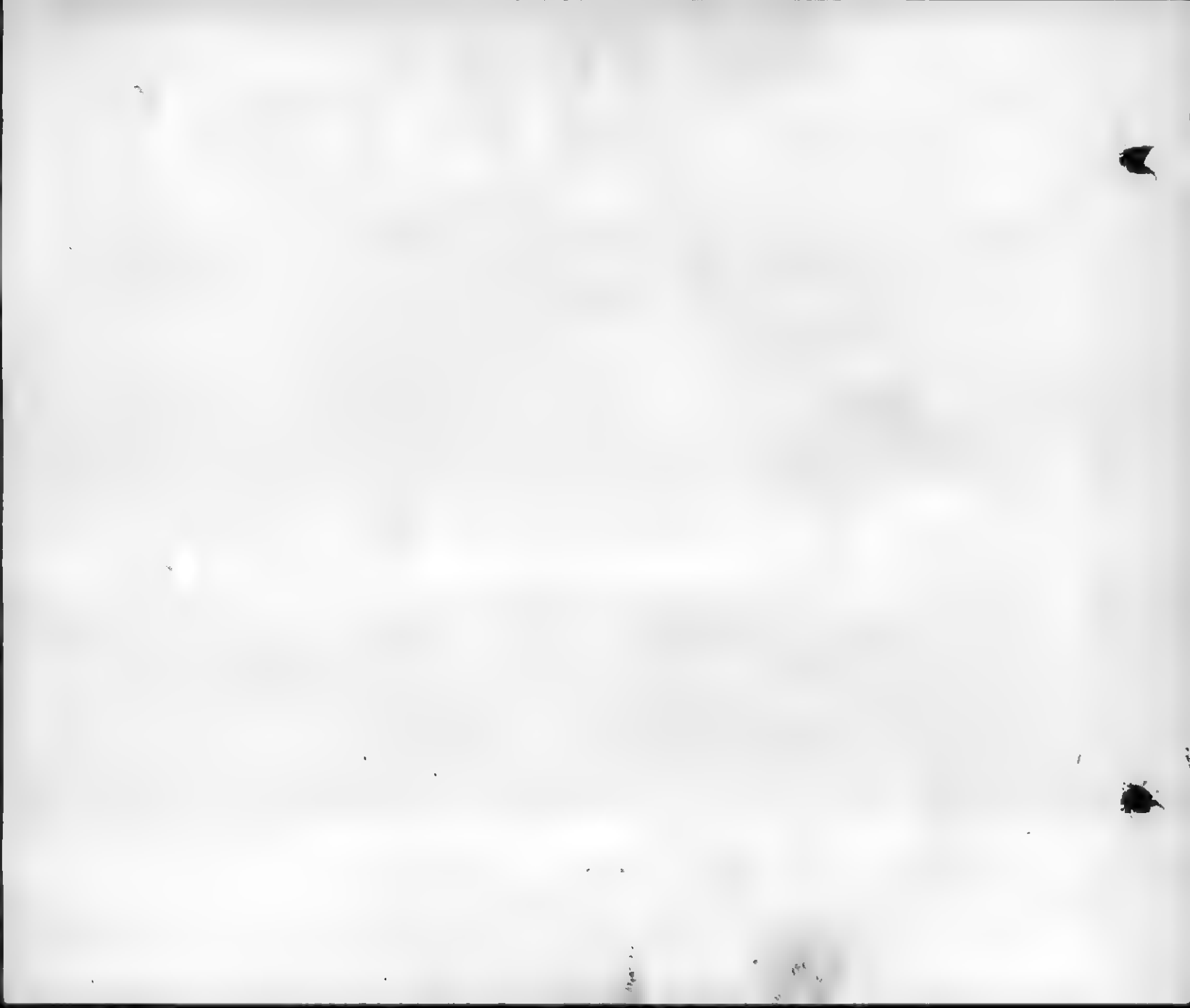
1 2,9 311-8247 12-29-58 et 14370 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

14368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN TB <u>2441</u> days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Ellis</u> Last <u>Ellis</u>		4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? Approx.</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Samuel Ellis</u>		14. MOTHER'S MAIDEN NAME <u>Libe Libbith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Hospital Records, Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>351X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min. ?</u> Years <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Residual left hemiplegia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 2</u> , 19 <u>52</u> , to <u>Dec. 16</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>Dec. 16</u> , 19 <u>58</u> , and that death occurred at <u>7:15A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Kosmahly</u> M.D.		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>12/16/58</u>	
PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	



14371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HEBRON</u>	
c. LENGTH OF STAY, IN 1b <u>1 MON</u>		d. STREET ADDRESS <u>MAIN ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Emrich</u> Last <u>H</u>		4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1879</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEDICAL DOCTOR GEN. PRACTICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERMAN EMRICH</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA VONDER HYDE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MR. Wm. S. Emrich, Annapolis, Md.</u>		Address <u>Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Vascular Accident</u> <u>155.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Carcinoma (adenocarcinoma) Stomach</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Prostatic Hypertrophy, Urologic Neck Obstruction</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Nov. 12, 1958</u> to <u>Dec 15, 1958</u> that I last saw the deceased alive on <u>Dec 15, 1958</u> , and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above	
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>William B Long</u>		M.D. <u>Richard C. Smith, Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>William B Long</u>		MEDICAL CENTER, SALISBURY, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>12/18/58</u>	<u>HEBRON CEMETERY</u>	<u>HEBRON, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hilt Johnson, Salisbury, Md.</u>		ADDRESS <u>Norman B. Baker</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>DEC 13 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u>		c. LENGTH OF STAY IN 1b <u>5 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maple Shade Nursing Home</u>		d. STREET ADDRESS <u>Hebron</u>	
3. NAME OF DECEASED (Type or print) <u>Maria</u> <u>Gambrill</u>		4. DATE OF DEATH Month <u>12-</u> Day <u>4-</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-12-1880</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>22</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Isaac Kennerly</u>		14. MOTHER'S MAIDEN NAME <u>Mary Phippips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u> <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Bert Thomas, Hebron, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio-sclerotic cardio-vascular disease—Years</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured right hip.</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell at home.</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-6-58</u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Hebron</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>1-12-59</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hebron Cem.</u>		22d. LOCATION (City, town, or county) <u>Hebron, Md.</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Messing, Belver, Md.</u>		24a. REC'D BY REG. STRAR <u>DAVID 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u></u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

REPLACEMENT CERTIFICATE

FILM # 238 1/23/59 ams

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

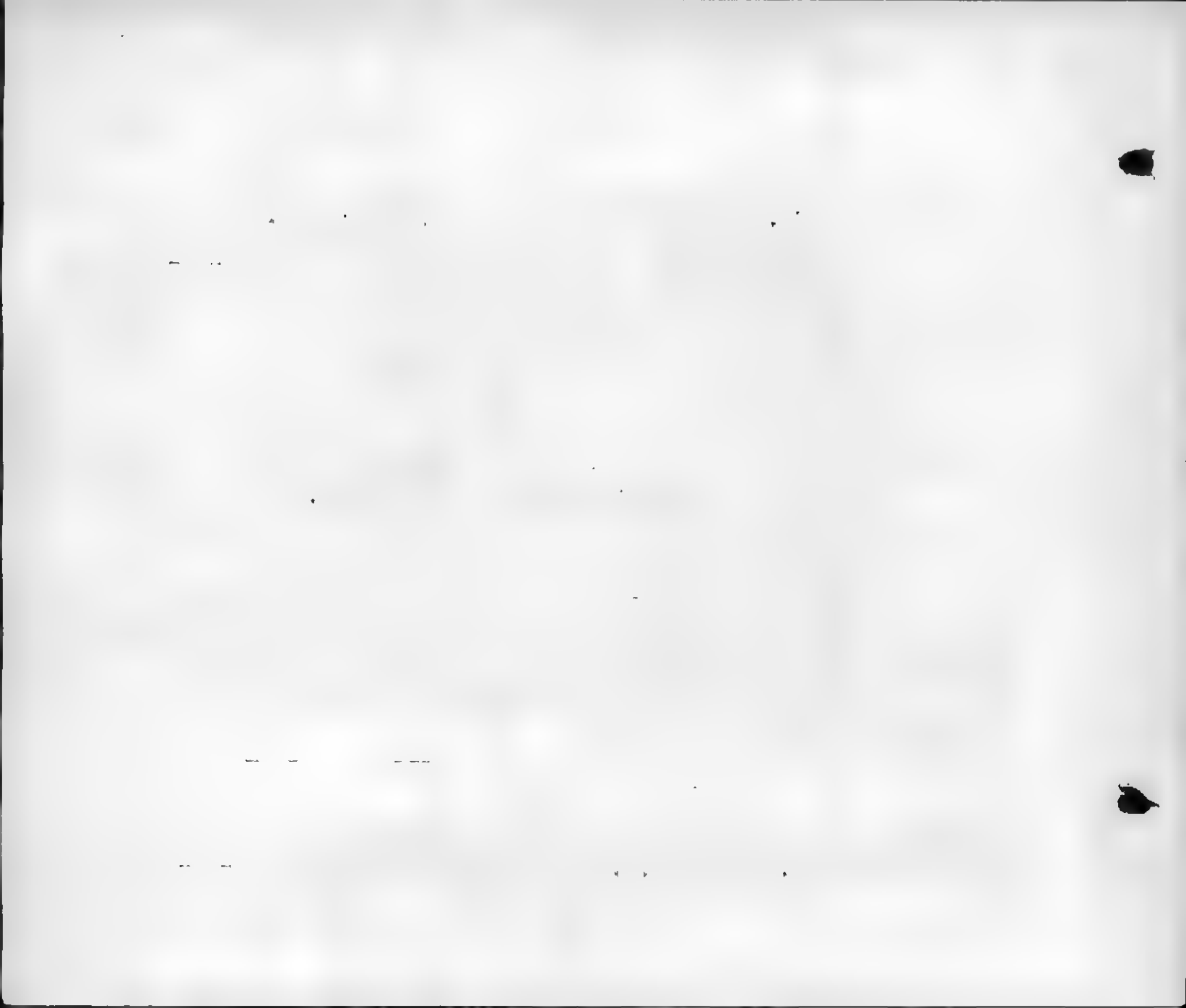
VS A15AE
SM 2:57

14372

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 700 Rose St.		d. STREET ADDRESS 700 Rose St.		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sylvia Mae Garton		4. DATE OF DEATH Month 12 Day 17 Year 1958		5. SEX F	
6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Henry Garton		14. MOTHER'S MAIDEN NAME Beulah Garton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Henry Garton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute interstitial pneumonitis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Hours _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-19-58	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-58		22c. NAME OF CEMETERY OR CREMATORY Brown Heron Cem	
22d. LOCATION (City, town, or county) Salisbury, Md		22e. (State) Md		23. FUNERAL DIRECTOR'S SIGNATURE Charles M. White	
24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE W. S. G. G. G.			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14435

14373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 8 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Longwoods		d. STREET ADDRESS Deer's Head State Hospital	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Gibson Last Gibson		4. DATE OF DEATH Month December Day 29 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1885
9. AGE (In years last birthday) 73 yrs.		10. MONTHS 73	11. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Gibson		14. MOTHER'S MAIDEN NAME Katherine Copper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. -	
17. INFORMANT Deer's Head Hospital Records, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease			
422.1 DUE TO (b) Arteriosclerosis general			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe chronic rheumatoid multiple arthritis with deformation			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29 , 19 58 , to Dec. 29 , 19 58 that I last saw the deceased alive on Dec. 29 , 19 58 , and that death occurred at 11:30 A.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Dr. V. Juerman		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/29/58	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-1-59	22c. NAME OF CEMETERY OR CREMATORY Richards Ann.	22d. LOCATION (City, town, or county) (State) Porton Md.
23. FUNERAL DIRECTOR'S SIGNATURE Isomer B. Dashiell		ADDRESS Porton, Md.	
24a. REC'D BY REGISTRAR DATE JAN 2 1959		24b. REGISTRAR'S SIGNATURE John L. P. ...	



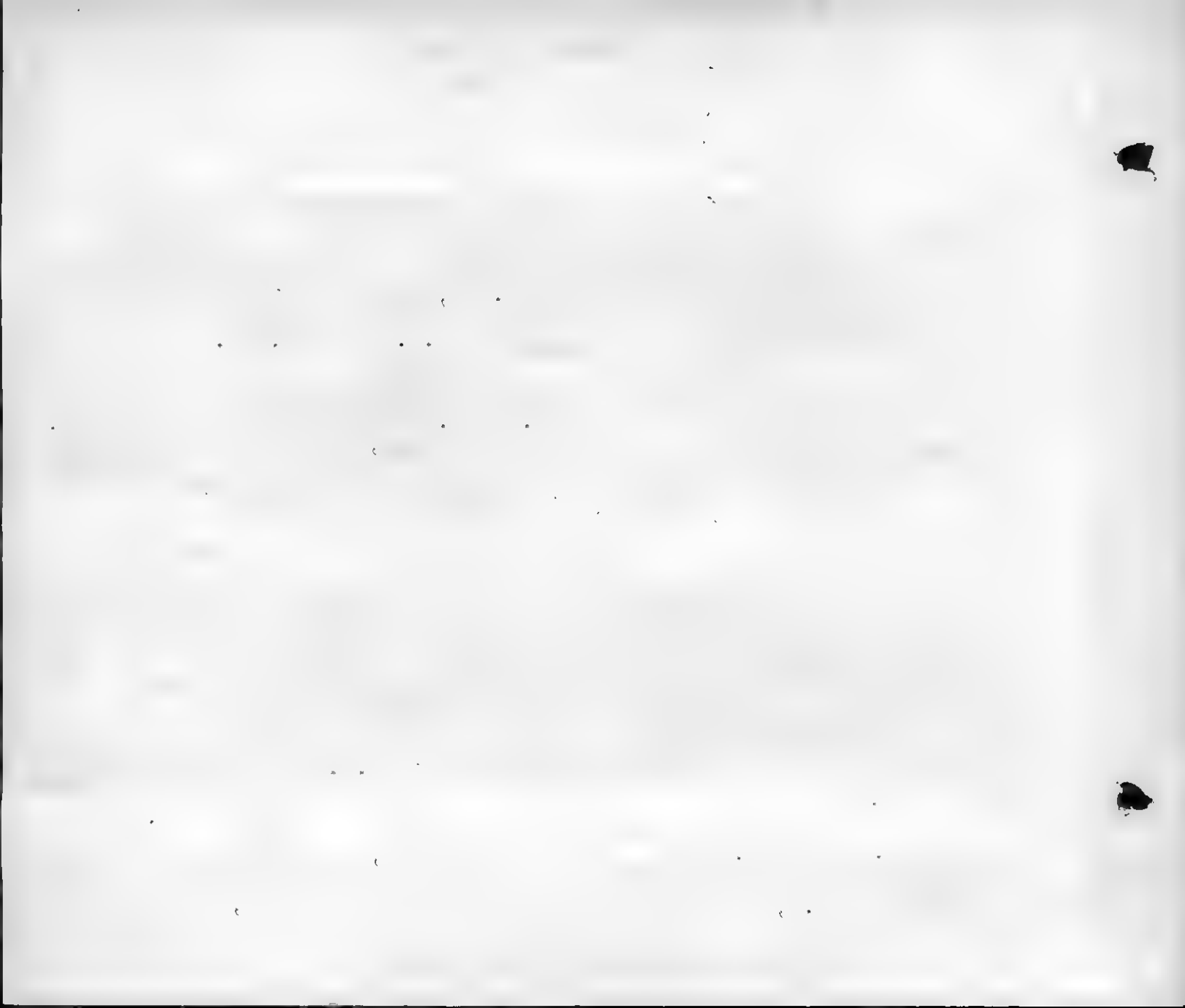
14374
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 629 Railroad Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
f. STREET ADDRESS 629 Railroad Ave		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIAM GORDY		4. DATE OF DEATH Month Day Year DECEMBER 2nd 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1st, 1865
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lumberman & Shirt Manufacture		10b. KIND OF BUSINESS OR INDUSTRY R.D. # Laurel, Del.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Gordy		14. MOTHER'S MAIDEN NAME Nancy Pusey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Ida M. Gordy (Wife) 629 Railroad Ave. Salisbury, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intra cranial Accidents DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerosis DUE TO (c) Mechanical Prostate Blockage		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1 , 19 58 , to 12/2 , 19 58 , that I last saw the deceased alive on 12/2 , 19 58 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Smith		DATE SIGNED Dec. 5, 1958	
PHYSICIAN'S NAME (Type) Dr. William B. Smith		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-	22b. DATE THEREOF Dec. 5, 1958	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DEC 8 '58	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14375

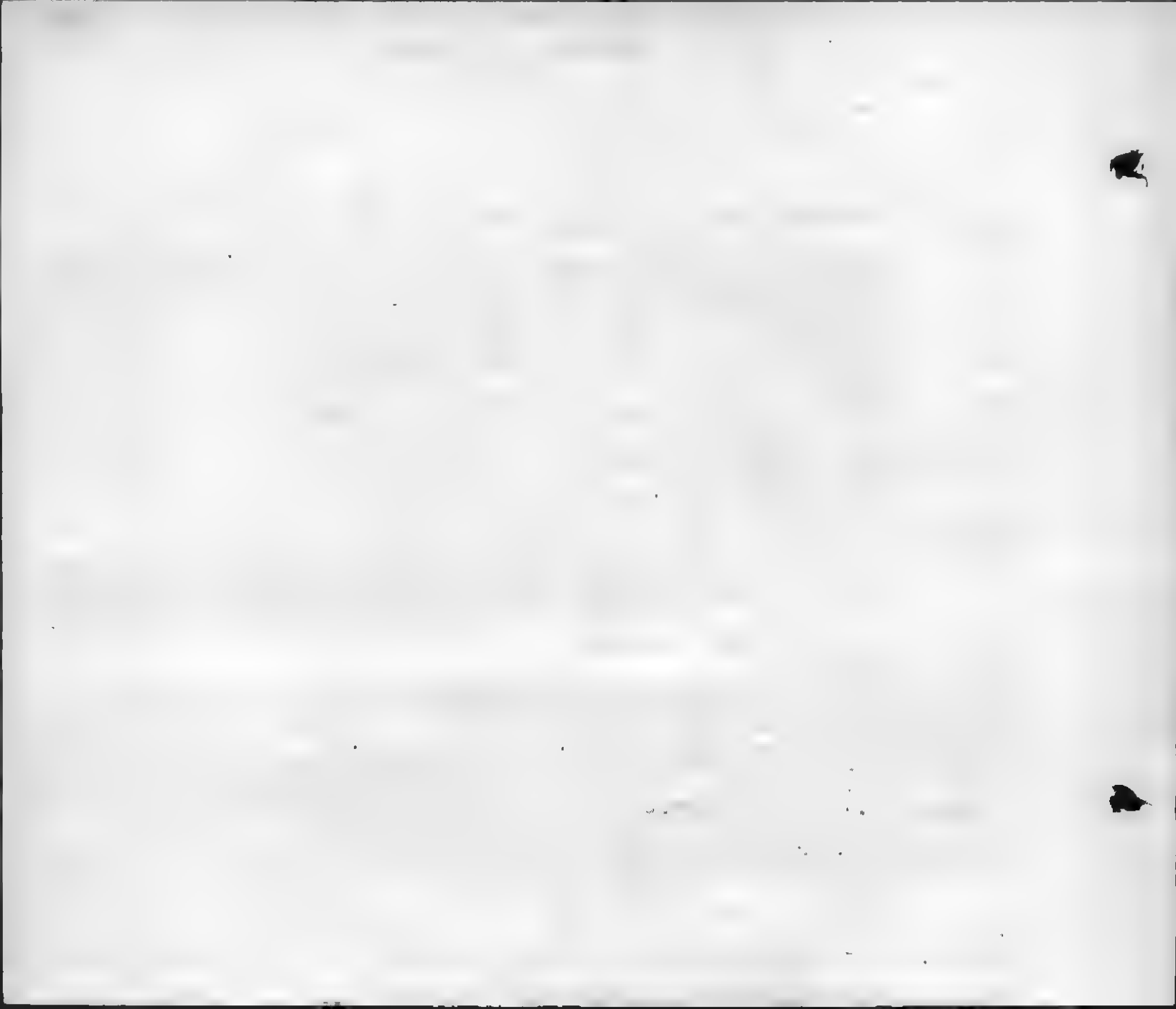
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. STREET ADDRESS 100 Park Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oda Middle Green Last Green				4. DATE OF DEATH Month Dec. Day 15 Year 19 58			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73		IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?				10b. KIND OF BUSINESS OR INDUSTRY ?			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas Green				14. MOTHER'S MAIDEN NAME Rose Camper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital Records Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of colon with metastasis							
1003.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 12, 19 58 to Dec. 15, 19 58 that I last saw the deceased alive on Dec. 15, 19 58 , and that death occurred at 11:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. V. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/15/58			
PHYSICIAN'S NAME (Type) Dr. V. Juerman				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/1958		22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold H. McLaughlin Jr.				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DEC 19 1958	
				24b. REGISTRAR'S SIGNATURE Charles E. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



R1
FOR STATE
HEALTH DEPT.

14376

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14374

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wic</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wic</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>419 Race St.</u>		e. STREET ADDRESS <u>419 Race St.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Dilford Greer</u>		4. DATE OF DEATH <u>Dec. 25</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 3-1909</u>
9. AGE (in years last birthday) <u>49</u> yrs		10. IF UNDER 24 HRS. Months <u>9</u> Days <u>22</u> Hours <u>—</u> M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber (Employee)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Greer</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute alcoholism</u> <u>3ddo</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Instey</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A. Instey</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Simmons Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Worcester Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wilbur J. Company Salisbury Md</u>		24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

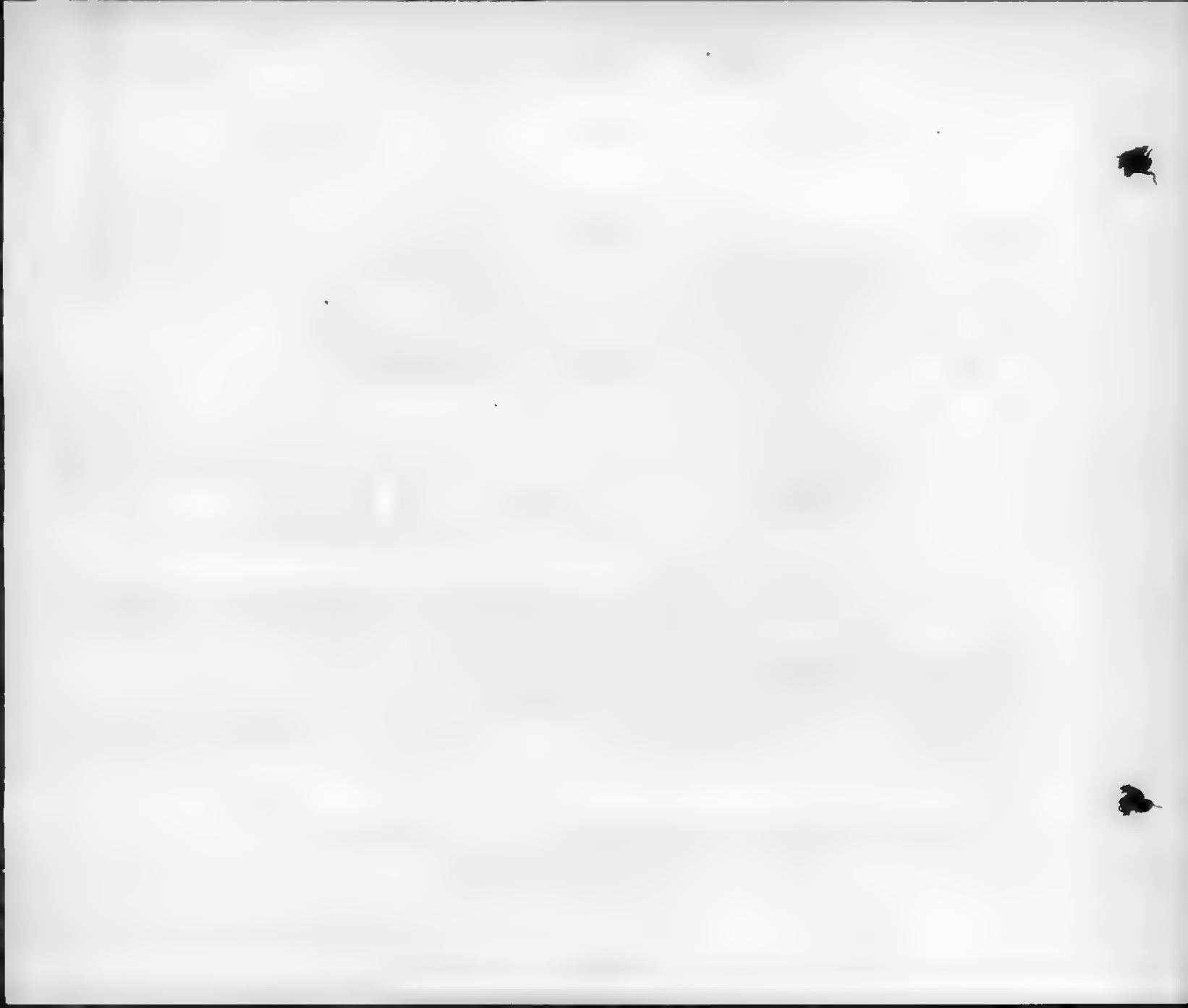
14375

14416

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Norman</u> Last <u>Stonford</u>		4. DATE OF DEATH 12-13-1958 Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>72</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
13. FATHER'S NAME <u>Ebner Stonford</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Stonford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>—</u> If yes, give war or dates of service <u>—</u>		16. SOCIAL SECURITY NO. <u>7</u>	17. INFORMANT Address <u>—</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Disease</u> DUE TO <u>Hypertensive Cardio-Vascular Bend</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Week</u> <u>2 years</u> <u>unk</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Nephritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 14, 1958</u> to <u>Dec 13, 1958</u> , that I last saw the deceased alive on <u>Dec 12, 1958</u> , and that death occurred at <u>2:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Herbert Semblly</u>		ADDRESS (Street, city or town, state) <u>400 E Church St Salisbury Md</u>	
PHYSICIAN'S NAME (Type) <u>G. Herbert Semblly</u>		DATE SIGNED <u>12/19/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-21-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frederick</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert McVee</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>



14417

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mapleway Box# 90		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLEN Middle MABEL Last HASTINGS		4. DATE OF DEATH Month DEC. Day 6 th Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1873
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY R.D.# Salisbury, Md	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Noah F. Jenkins		14. MOTHER'S MAIDEN NAME Martha Ellen Farlow	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Howard J. Hastings (Son) Box#90 Mapleway Salisbury, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) arteriosclerotic Heart disease 420.0 DUE TO C failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 month (c) 1 month		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/16 , 19 55 , to death , 19 58 , that I lost sowed the deceased alive on 11/15 , 19 58 , and that death occurred at 11:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Del DATE SIGNED 12/19/58			
ACTUAL SIGNATURE Ernest M. Larmore M.D.		PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore Delmar, Delaware Dec. 8 /1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 9, 1958	22c. NAME OF CEMETERY OR CREMATORY Charity Church Cemetery	22d. LOCATION (City, town, or county) (State) R.D.# Salisbury, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR DEC 9 '58	
ADDRESS SALISBURY, MARYLAND		24b. REGISTRAR'S SIGNATURE John S. Larmore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14377

CERTIFICATE OF DEATH

14377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				d. STREET ADDRESS 522 E. Locust St			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ASBURY Last HOLLOWAY JR.				4. DATE OF DEATH Month December Day 5th Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Single <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 4, 1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) R.D.# Hebron, Maryland	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME William Asbury Holloway				14. MOTHER'S MAIDEN NAME Annie E. Dykes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
				17. INFORMANT Miss Nettie R. Holloway (Sister) 522 E. Locust St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery (accident) - 501A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Wicomico		20h. (State) Maryland	
21. I certify that I attended the deceased from 12/5 , 19 58 , to 12/5 , 19 58 , that I last saw the deceased alive on 12/5 , 19 58 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Andrew C. Mitchell				DATE SIGNED December 7, 1958			
PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell				ADDRESS Maryland Ave. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DEC 9 1958	
24b. REGISTRAR'S SIGNATURE John S. Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14378

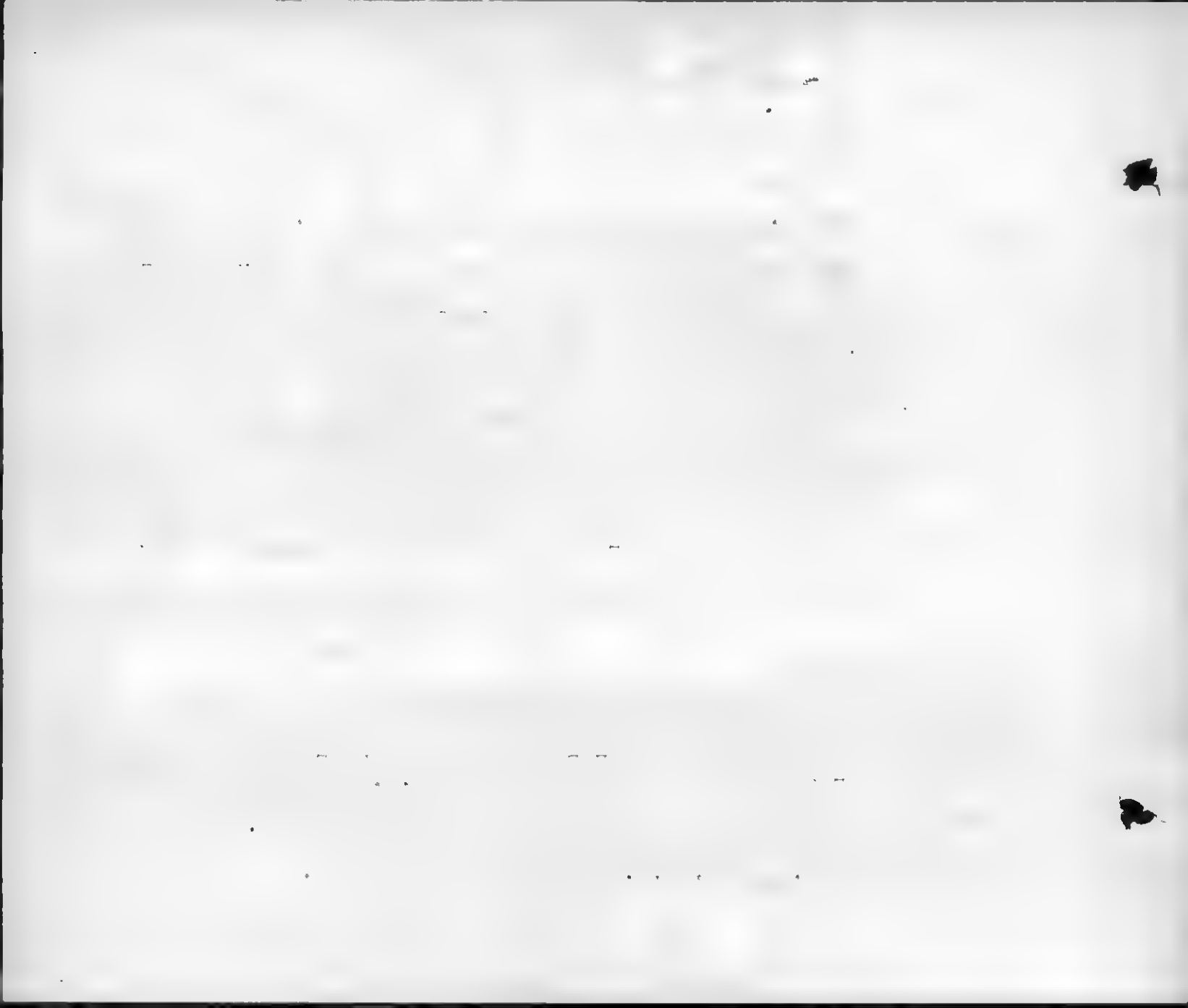
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ellagood St.</u>		d. STREET ADDRESS <u>Ellagood St.</u>	
3. NAME OF DECEASED (Type or print) <u>Emmaline</u>		4. DATE OF DEATH Month <u>12-</u> Day <u>20-</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-1867</u>
9. AGE (In years last birthday) <u>91</u> yrs		IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Mrs Donald Bowden, Salisbury, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic cardio-vascular disease—Years</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-1-58</u> , 19 <u>58</u> , to <u>12-20-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-1-58</u> , 19 <u>58</u> , and that death occurred at <u>4 P.M.</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		ADDRESS (Street, city or town, state) <u>407 Camden Ave.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bivalve Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bivalve, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Wessitt, Bivalve, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>DEC 29 1958</u>		24b. REGISTRAR'S SIGNATURE <u>John E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14379

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

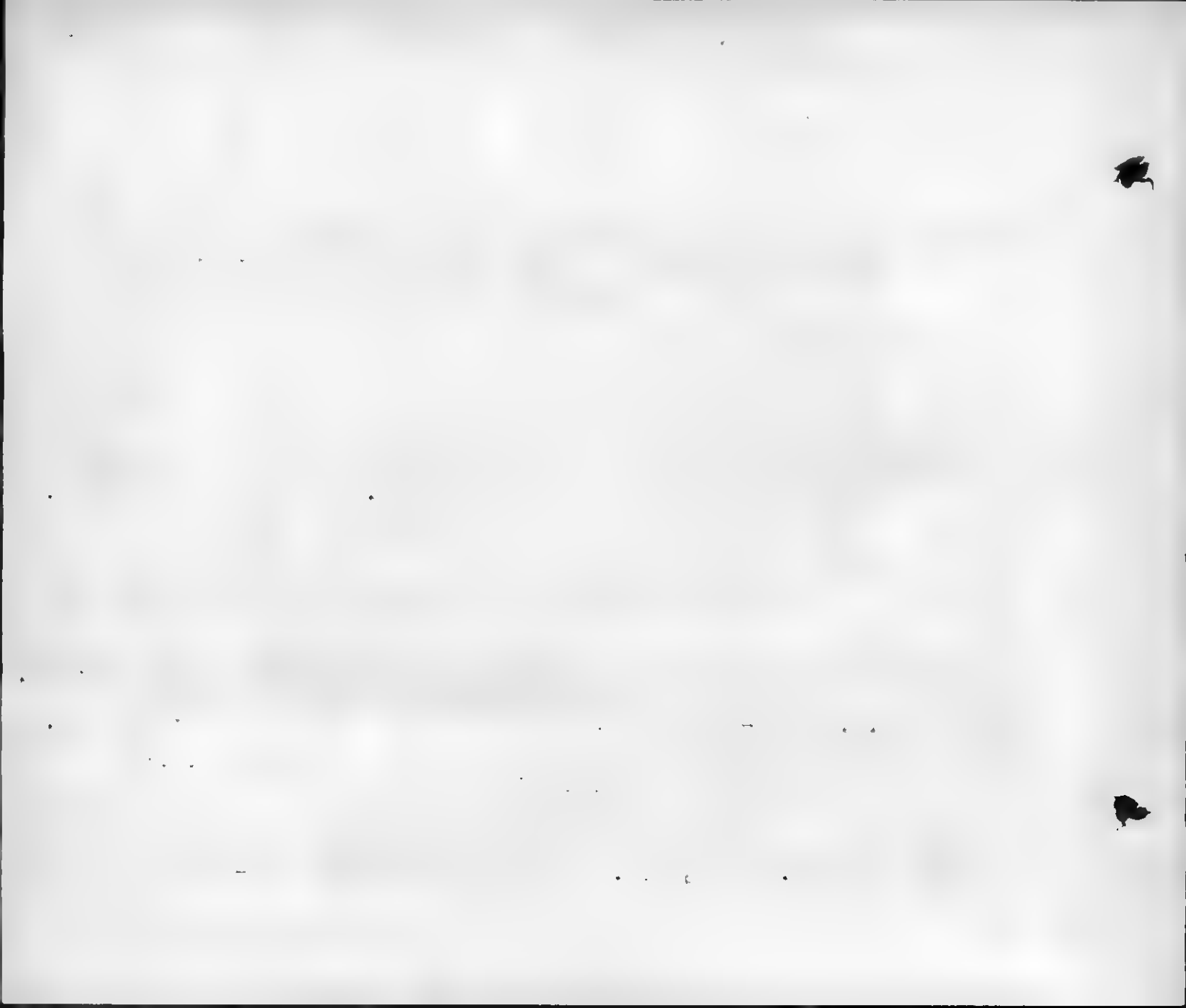
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If inst. tuition, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Salisbury</u>	
b. CITY OR TOWN (If outside corporate limits, write PLURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>Route # 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Milton Jackson</u>		4. DATE OF DEATH <u>12-21-</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-17-27</u>
9. AGE (In years last birthday) <u>31</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Wagner Markat</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Dr. Earl L. Royer</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon monoxide poisoning.</u> <u>91.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Parked in car with motor running with faulty exhaust.</u>	
20c. TIME OF INJURY Month, Day, Year <u>12:30 P.M. 12-21-58</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>12-23-58</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-27-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's</u>		22d. LOCATION (City, town, or county) <u>Salisbury</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl L. Royer</u>		ADDRESS <u>Salisbury</u>	
24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Earl L. Royer</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the files of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

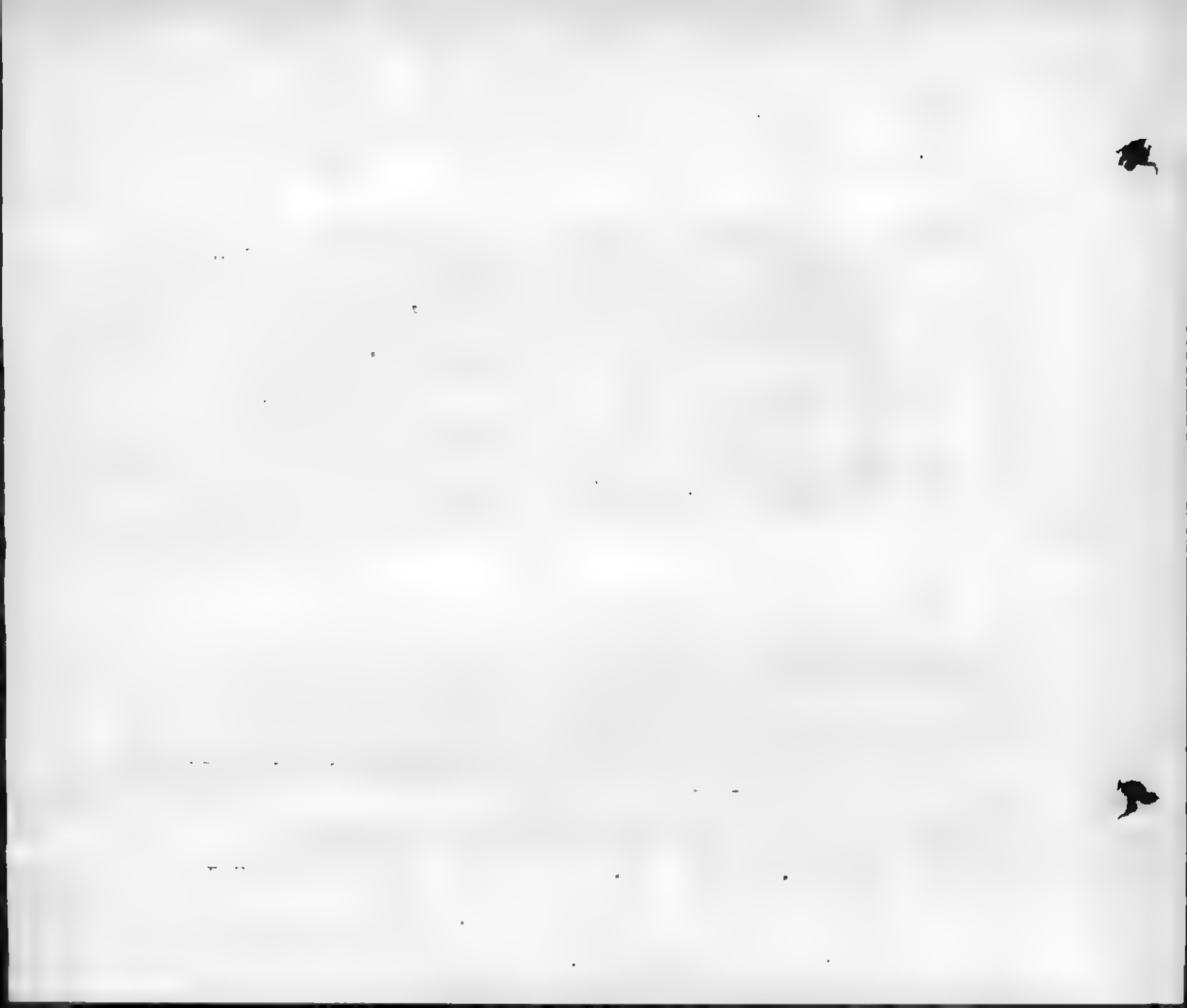
14418 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14380

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ebbie</u> <u>P</u> <u>Jones</u>		4. DATE OF DEATH Month Day Year <u>12</u> <u>6</u> <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 17, 1958</u>
9. AGE (in years last birthday) yrs <u>10</u> Months <u>10</u> Days <u>19</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Alton Jones</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Lucy Jones, White Haven, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> <u>5325 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Hours <u></u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>12-9-58</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) <u>12/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>White Haven Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>White Haven, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick, P. D. 1, d.</u>	
24a. REC'D BY REGISTRAR <u>DEC 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14380

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First Middle Last				4. DATE OF DEATH <u>December 29</u> 19 <u>58</u> Month Day Year			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>Colored</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4-11-06</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)	
12 CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16 SOCIAL SECURITY NO		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Artemia</u> <u>447x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive vascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>11</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-22</u> , 19 <u>58</u> , to <u>12-29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-29</u> , 19 <u>58</u> , and that death occurred at <u>11:59</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>1-2-59</u>			
PHYSICIAN'S NAME (Type)							
22a BURIAL, CREMATION, REMOVAL (Specify)		22b DATE THEREOF		22c NAME OF CEMETERY OR CREMATORY		22d LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-1-59</u>		<u>Salisbury</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE <u>JAN 6 '59</u>		24b. REGISTRAR'S SIGNATURE	
<u>Funeral Home</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14381

CERTIFICATE OF DEATH

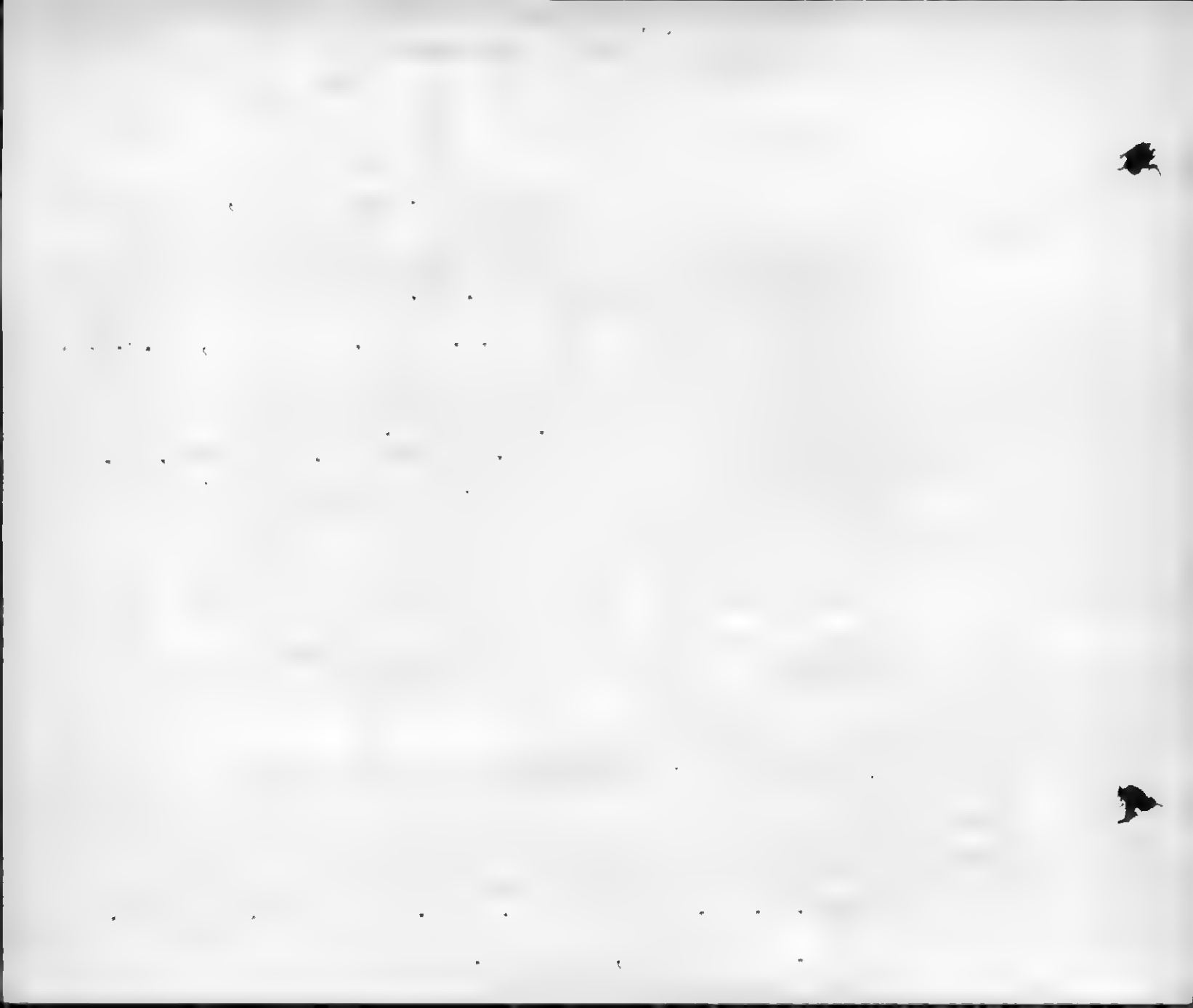
14382

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>		d. STREET ADDRESS <u>226 E. College Ave,</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Christopher Lawrence</u>		4 DATE OF DEATH Month Day Year <u>December 31 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30. 1958</u>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>P.G. Hospt. Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles William Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Joan Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mr. Charles W. Lawrence (Father)</u>		Address <u>226 E. College Ave. Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis of both lungs</u> 762- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>"</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital absence of both kidneys.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/30 1958</u> to <u>12/30 1958</u> , that I last saw the deceased alive on <u>12/30 1958</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>211 Maryland Salisbury Md 1/2/59</u>			
ACTUAL SIGNATURE <u>CC Smith</u>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Type)	22b. DATE THEREOF <u>Jan. 2. 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park.</u>	22d. LOCATION (City town or county) (State) <u>Salisbury, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co.</u>		ADDRESS <u>Salisbury, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>Jan 3 59</u>		24b. REGISTRAR'S SIGNATURE <u>a. Smith</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14383

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>H.</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1889</u>
9. AGE (In years last birthday) <u>69</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>chicken farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jake Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Ann LeCento</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, do or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>214-12-5069</u>	
17. INFORMANT <u>Anna Brittingham</u>		Address <u>Seely Bay, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 8, 1958</u> to <u>Nov. 14, 1958</u> , that I last saw the deceased alive on <u>Nov. 14, 1958</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>Pine Bluff, Ark.</u>	
PHYSICIAN'S NAME (Type) <u>John C. Hill, Jr., M.D.</u>		DATE SIGNED <u>12/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Whaleysville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Whaleysville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14383

14382

CERTIFICATE OF DEATH

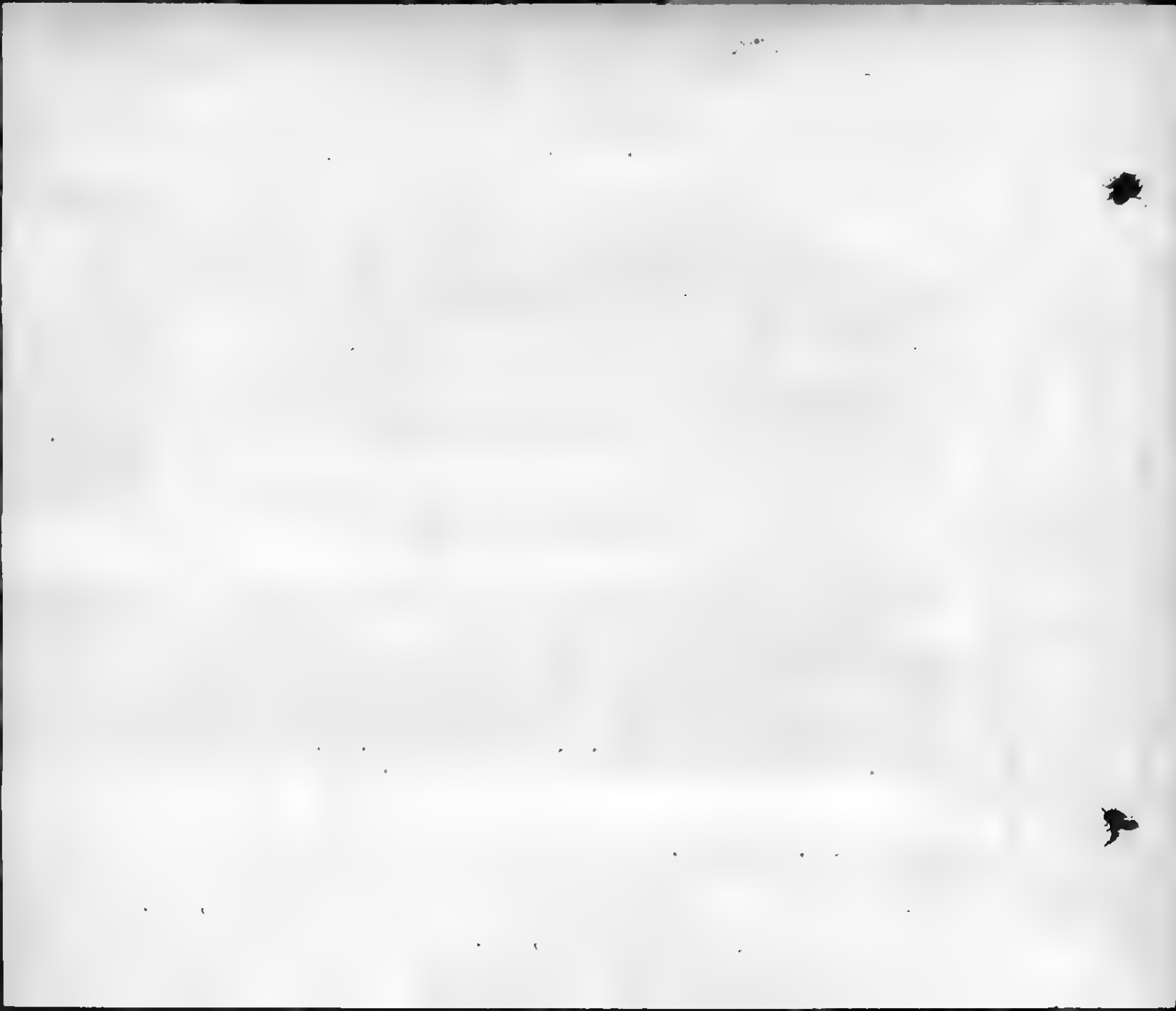
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS --			
3. NAME OF DECEASED (Type or print) First Middle Last Ida Bell Lewis				4. DATE OF DEATH Month Day Year December 23, 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1874	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Federalsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U SA	
13. FATHER'S NAME Andrew Beauchamp				14. MOTHER'S MAIDEN NAME Louise Beauchamp (Fluharty)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 214-12-6859D		17. INFORMANT Address Deer's Head State Hospital Records, Salisbury, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis generalized DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 24 hours Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 9, 1954 to Dec. 23, 1958 , that I last saw the deceased alive on Dec. 23, 1958 , and that death occurred at 2:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 12/23/58 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/26/58		22c. NAME OF CEMETERY OR CREMATORY Bloomery Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. V. Maldve				24a. REC'D BY REGISTRAR DATE DEC 29 58		24b. REGISTRAR'S SIGNATURE L. V. Maldve	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14384

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>3.4 HARRISON ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LONG</u>		4. DATE OF DEATH Month Day Year <u>DECEMBER 25 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 24, 1905</u>
9. AGE (In years last birthday) yrs <u>53</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min <u>21 33</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Earl R. Long</u>		14. MOTHER'S MAIDEN NAME <u>Marcie Boyce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Earl R. Long</u>		Address <u>304 Harrison St Salisbury Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary atherosclerosis (Sclerotic)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>14</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/25/58</u> to <u>12/25/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/25/58</u> , 19 <u>58</u> , and that death occurred at <u>3:47</u> A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>304 Harrison St Salisbury Md.</u> DATE SIGNED <u>12/26/58</u>			
ACTUAL SIGNATURE <u>Earl R. Long</u>		PHYSICIAN'S NAME (Type) <u>Earl R. Long</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest L. Hansen</u>		ADDRESS <u>Princess Anne Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14385

CERTIFICATE OF DEATH

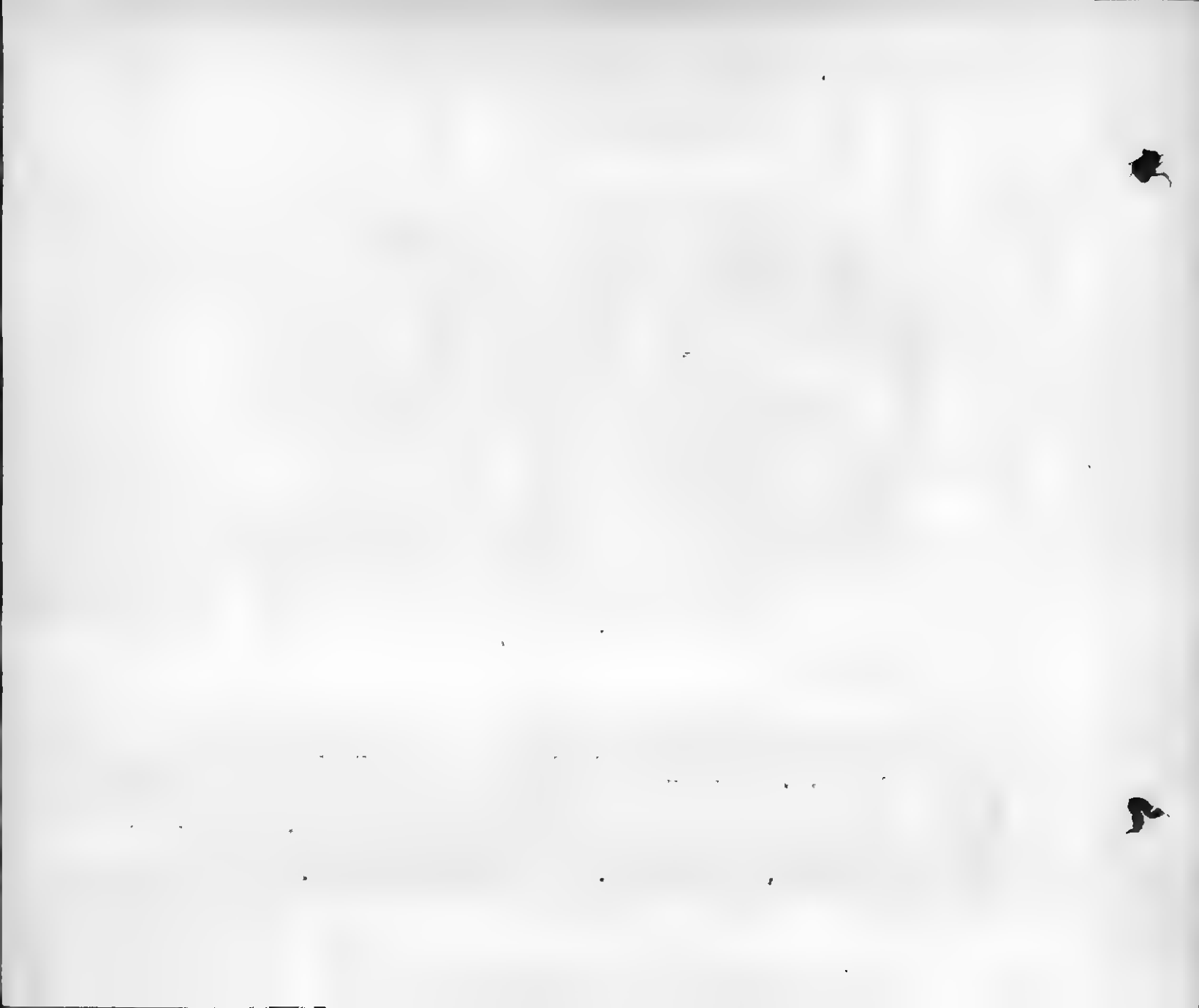
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lincolnton General Hospital</u>				d. STREET ADDRESS <u>613 Main St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROLAND WILLIAM Long</u>				4. DATE OF DEATH Month Day Year <u>December 12 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 19, 1904</u>	9. AGE (In years last birthday) <u>54</u> yes	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lock-making</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>WALTER B. LONG</u>				14. MOTHER'S MAIDEN NAME <u>MATTHE L LONG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Clayton Long</u> Address <u>Salisbury</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriolar nephro sclerosis</u> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio sclerosis.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-24-58</u> , 19 <u>58</u> , to <u>12-12-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3:30 P.M.</u> , <u>12-11-58</u> that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>407 Camden Ave.</u> DATE SIGNED <u>12-12-58</u>							
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.				DATE SIGNED <u>12-12-58</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ADDRESS <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Dec 14 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Vogel</u> ADDRESS <u>Salisbury</u>				24a. REC'D BY REGISTRAR <u>DEC 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14387

Item 18 Film 237 14386

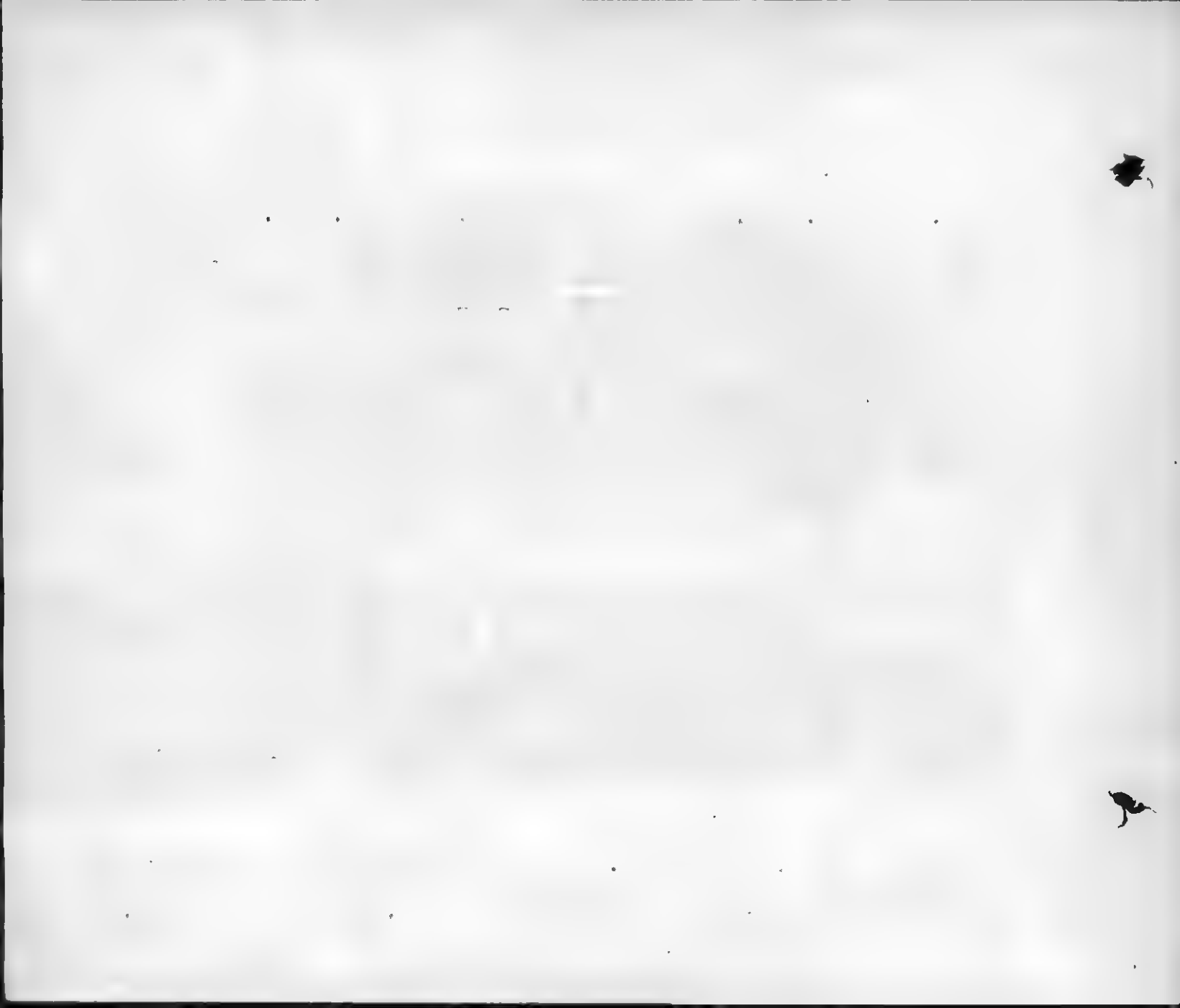
14386

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>E. Vine St. Ext.</u>		e. STREET ADDRESS <u>E. Vine St. Ext.</u>	
3. NAME OF DECEASED (Type or print) First <u>Roderick</u> Middle <u>MacMillan</u> Last <u>MacMillan</u>		4. DATE OF DEATH Month <u>12-</u> Day <u>13-</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-06</u>
9. AGE (in years last birthday) <u>52</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>James MacMillan</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Farrell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Alfred MacMillan</u>		Address <u>Regency Drive, City</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> g. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		DATE SIGNED <u>12-15-58</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Pk.</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Wallace</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Pratt</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be filed as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14387 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14436

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
c. LENGTH OF STAY IN 1b <u>17 Years</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>John Maddox</u>		4. DATE OF DEATH Month Day Year <u>12-26-1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/1941</u>
9. AGE (In years and days) <u>17 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME <u>JOHN MADDOX</u>		14. MOTHER'S MAIDEN NAME <u>CECIL YOUNG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO <u>212-41-7635</u>	
17. INFORMANT <u>LESTER FREDRICK, MCKINLEY</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Sickle cell anemia</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <u>12-31-58</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Charles Wesley</u>		22d. LOCATION (City, town or county) (State) <u>Marokine Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. James Jr.</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. J. P. H. A.</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14388 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke CITY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fennell's General Hospital</u>		d. STREET ADDRESS <u>Route #1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Archie P. Merrill</u>		4. DATE OF DEATH Month Day Year <u>December 8 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 19, 1880</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONTRACTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OLIVER S. MERRILL</u>		14. MOTHER'S MAIDEN NAME <u>EMMA JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MRS. BLANCHE D. MERRILL</u>		Address <u>POCOMOKE CITY, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Chronic Cor Pulmonale</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Pulmonary Fibrosis & Emphysema</u> (c) <u>Interarteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interarteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1958</u> , to <u>1958</u> , that I last saw the deceased alive on <u>1958</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry S. Gilmore</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
DATE SIGNED <u>Dec 8, 1958</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Gilmore</u>		ADDRESS <u>POCOMOKE CITY, MD.</u>	
24a. REC'D BY REGISTRAR <u>DEC 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Travis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

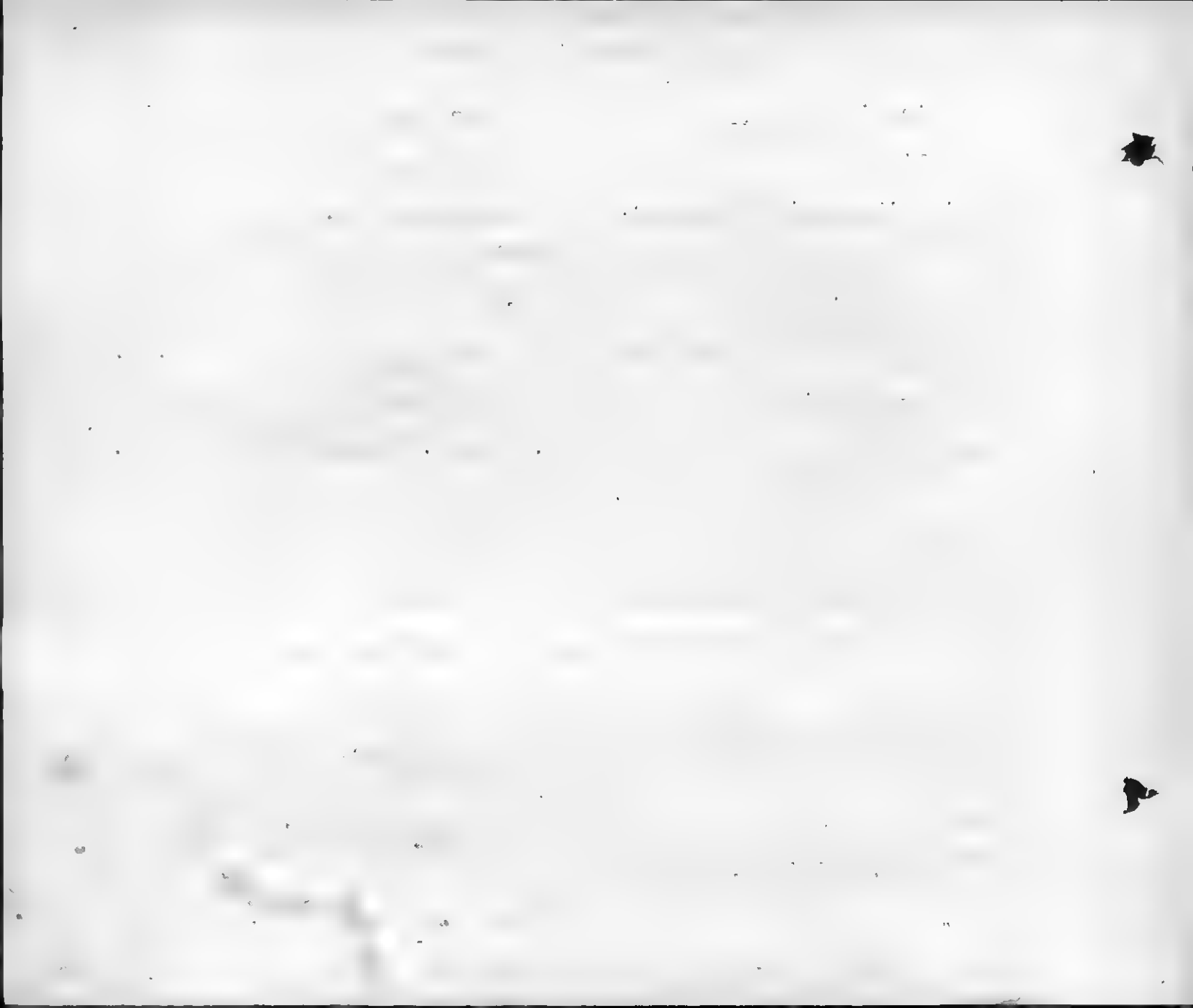


14389 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 Mons	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First May Middle Belle Lee Last Morris		4. DATE OF DEATH Month December Day 22 , Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1882
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Morris		14. MOTHER'S MAIDEN NAME Rosa Lee Tilghman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. John L. Morris, Salisbury, Md.		230 Middle Blvd.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular renal disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-26-58 to Dec. 22, 1958 , that I last saw the deceased alive on 12-26-58 , and that death occurred at 4:30 A. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley		ADDRESS (Street, city or town, state) 116 East Main St. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		DATE SIGNED DEC 22 '58	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/58	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		ADDRESS Norman T. Baker	
24a. REC'D BY REG. STRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE Carlton S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

14390

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury		LENGTH OF STAY (In this place) since 4/10/58		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural-Unionville-Pocomoke			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital				STREET ADDRESS (If rural give location) RFD # 2			
3. NAME OF DECEASED (Type or Print) CHARLES SNOW NIBLETT				4. DATE (Month) (Day) (Year) DEATH Dec. 28 19 58			
5. SEX M	6. COLOR OR RACE N	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M	8. DATE OF BIRTH March 1, 1886		9. AGE last birthday 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph - Joseph Niblett				14. MOTHER'S MAIDEN NAME Mahala Blades			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-16-6314		17. INFORMANT & ADDRESS Records of Pine Bluff State Hosp.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Pulmonary tuberculosis						4 yrs.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/10, 19 58, to 12/28, 19 58, that I last saw the deceased alive on 12/27, 19 58, and that death occurred at 7:50a M. from the causes and on the date stated above.							
SIGNATURE E.P. Ritchings				ADDRESS (Street, city, town, state) 12/28/58 DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12-31-58		NAME OF CEMETERY OR CREMATORY Baptist Cemetery		LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
24. REC'D BY REGISTRAR JAN 5 59 DATE		REGISTRAR'S SIGNATURE Henry A. Watson		25. FUNERAL DIRECTOR'S SIGNATURE Henry A. Watson		ADDRESS Pocomoke Md.	

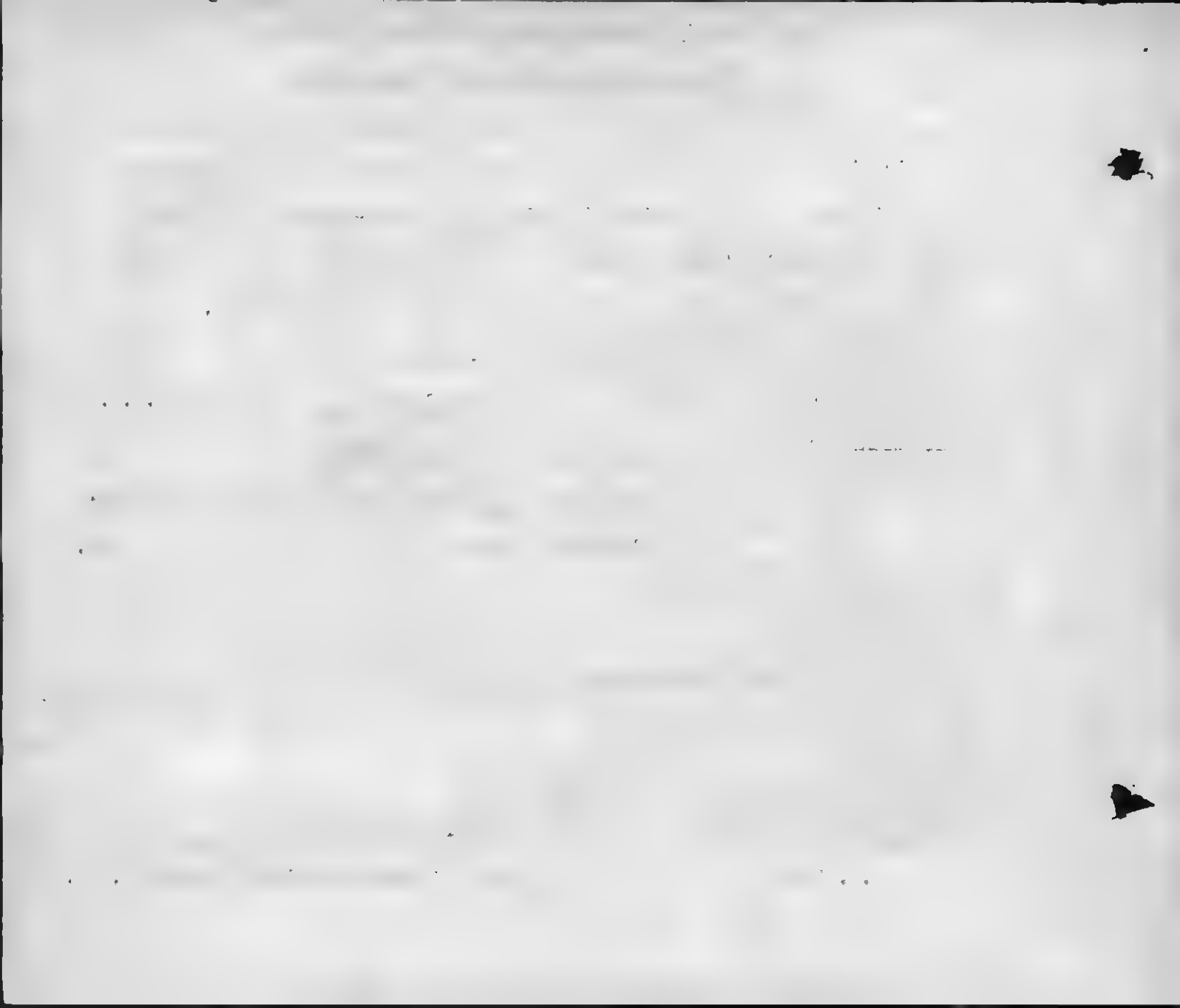
INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



14419

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nanticoke		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First MAGGIE Middle H. Last NUTTER		4. DATE OF DEATH Month Dec. Day 24 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 1 Days 19 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Westley Nutter		14. MOTHER'S MAIDEN NAME Sally----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO -----	
17. INFORMANT Nelson Nutter, Nanticoke, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized Arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 May 1947 to 24 Dec 1958 , that I last saw the deceased alive on 24 Dec 1958 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard H. Saunders M.D.		ADDRESS (Street, city or town, state) Nanticoke Md. DATE SIGNED 12/27/58	
PHYSICIAN'S NAME (Type) Richard H. Saunders		Nanticoke, Maryland 12/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/58	22c. NAME OF CEMETERY OR CREMATORY Nanticoke Cem.	22d. LOCATION (City, town, or county) (State) Nanticoke, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Messick, Bivalve, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DEC 31 '58		24b. REGISTRAR'S SIGNATURE William E. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14391 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Le. Chester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
c. LENGTH OF STAY IN 1b <u>37 days</u>		d. STREET ADDRESS <u>Rt # 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Palmer</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9, 1880</u>
9. AGE (in years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Hettie Littleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-1951</u>	
17. INFORMANT <u>Jennie Palmer Berlin Ind.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>37 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/13</u> , 19 <u>58</u> , to <u>12/20</u> , 19 <u>58</u> ; that I last saw the deceased alive on <u>12/19</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> A. M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Samuel J. Gilman</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>12/20/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremated</u>		22b. DATE THEREOF <u>12/23/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Salisbury Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DEC 20 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>S. J. Gilman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



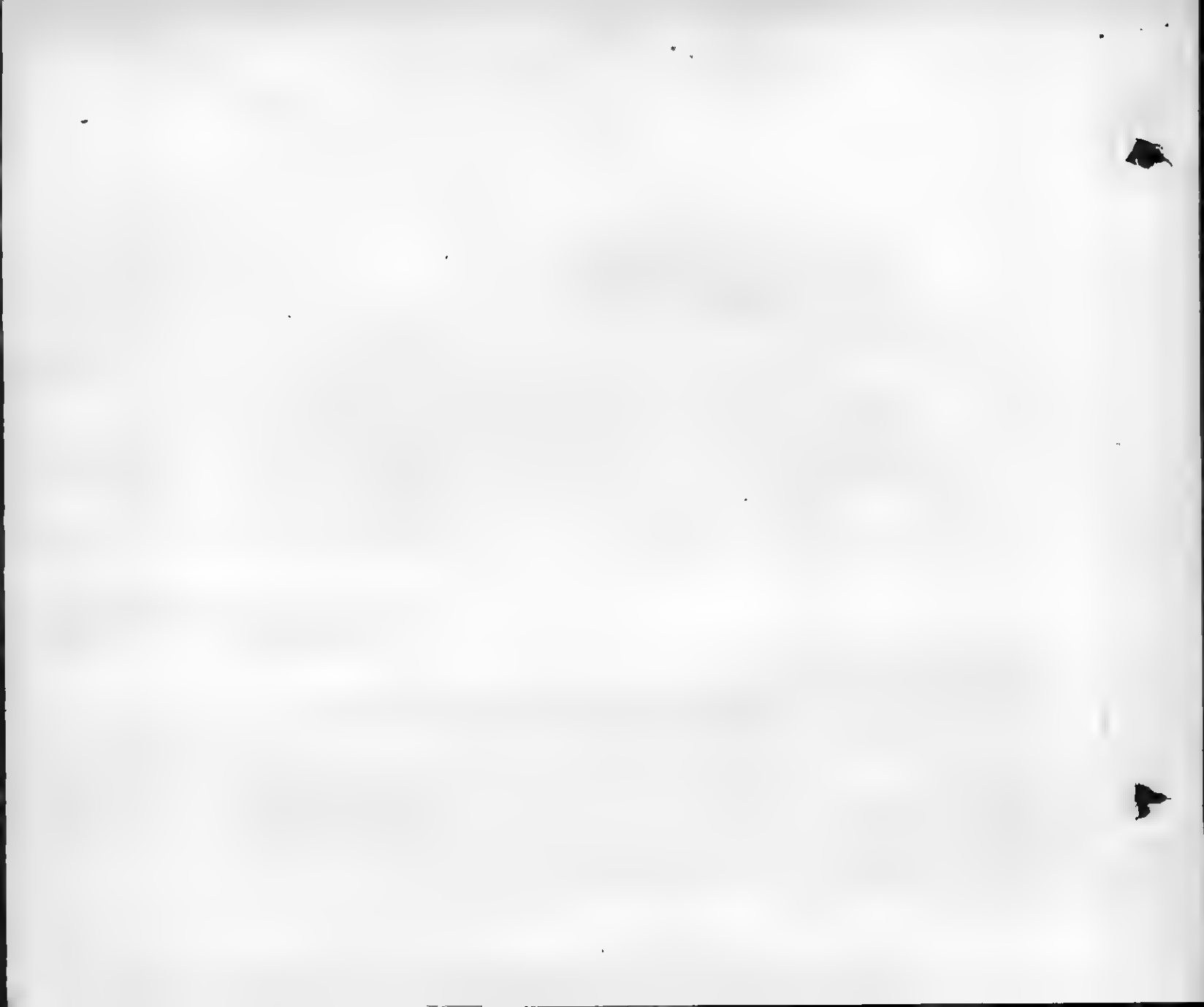
14392 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>3 HOURS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LENA E. Peacock</u>		d. STREET ADDRESS <u>301 MAPLE STREET</u>	
4. DATE OF DEATH Month Day Year <u>December 31 1958</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE E. BRITTINGHAM</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MR. ISAAC PEACOCK</u>		Address <u>POCOMOKE CITY, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular</u> DUE TO <u>unknown</u> (c) <u>disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-28</u> to <u>12-31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-31</u> , 19 <u>58</u> , and that death occurred at <u>9:00 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>SALISBURY, MARYLAND</u> <u>12/31/58</u>			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS JR.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Watson</u>		24a. REC'D BY REGISTRAR <u>IAN 6 '59</u>	
ADDRESS <u>POCOMOKE CITY, MD.</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14393

CERTIFICATE OF DEATH

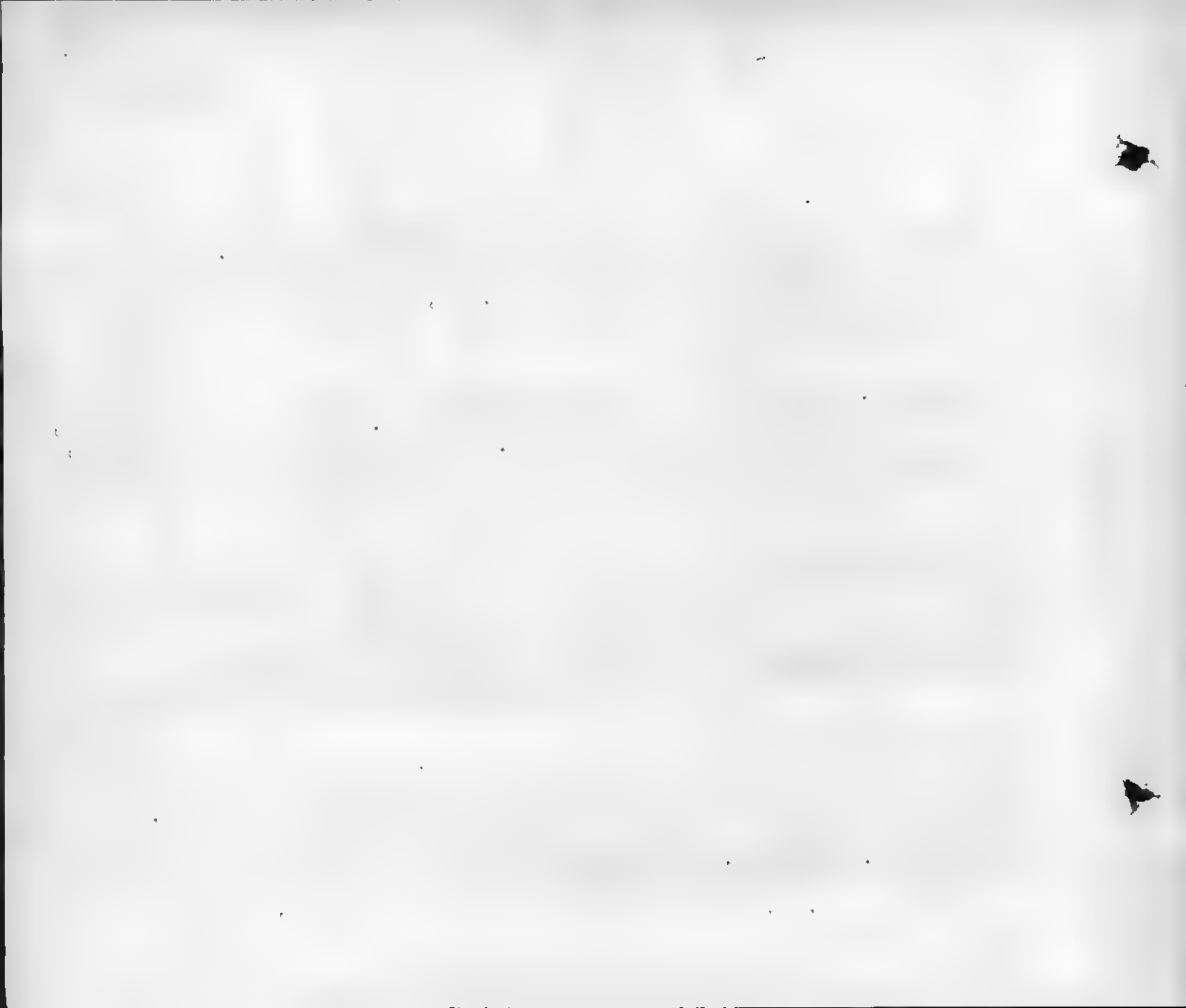
14394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY XXXXXXXXXX Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION John B. Parsons Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel 46X 3 ✓	
		d. STREET ADDRESS 103 Front St	
3. NAME OF DECEASED (Type or print) LENA First M Middle PLUMMER Last		4. DATE OF DEATH Month DEC. Day 20th Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1875
9. AGE (In years lost birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months 1 Days 3 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Laurel, Delaware	
13. FATHER'S NAME Hudson D. Plummer		12. CITIZEN OF WHAT COUNTRY? U S A	
14. MOTHER'S MAIDEN NAME Miranda Hitchens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Records—John B. Parsons Home—Salisbury, Md Address & Miss, Mattie Eskridge (Niece) Fredrick, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Cardiovascular renal disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Breast			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 19 57 , to Dec 20 , 19 58 , that I last saw the deceased alive on Dec 17 , 19 57 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D. Salisbury, Md		DATE SIGNED Dec. 22 1958	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		Main St Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 23, 1958	22c. NAME OF CEMETERY OR CREMATORY Odd Fellow Cemetery	22d. LOCATION (City, town, or county) (State) Laurel, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DEC 23 '58	24b. REGISTRAR'S SIGNATURE J. L. Hume

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14394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>105 LAUREL ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>F.</u> Last <u>POPE</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 5, 1870</u>	9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL WEBB</u>				14. MOTHER'S MAIDEN NAME <u>SALLY BEAUCHAMP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>MRS JENNIE POPE, Pocomoke City, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 18, 1958</u> , to <u>Dec 22, 1958</u> , that I last saw the deceased alive on <u>Dec 22, 1958</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u>		M.D. <u>Pine Bluff Road</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>12/23/58</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL JR.</u>		<u>Salisbury, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SALEM METHODIST</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry St. Watson</u>		ADDRESS <u>Pocomoke City, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 58</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. H. B. ...</u>	

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14395

CERTIFICATE OF DEATH

14437

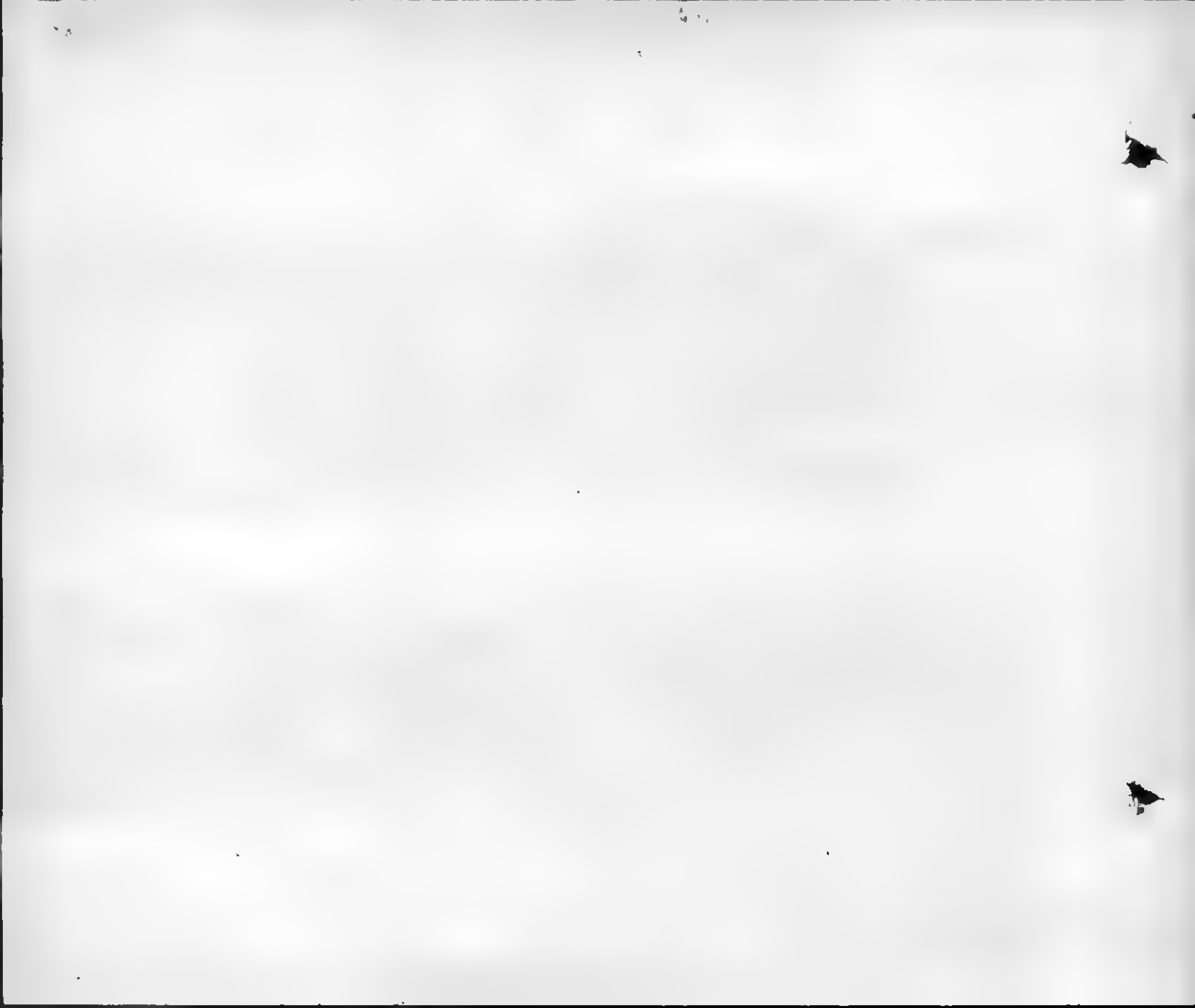
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Saxisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Penninsula General Hospital</u>		d. STREET ADDRESS <u>SAXIS</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>EMMA</u> First Middle Last		4. DATE OF DEATH <u>December 31</u> 19 <u>58</u> Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Approx. 73</u> yrs
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11 BIRTHPLACE (State or foreign country) <u>SAXIS</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John DENNIS</u>		14 MOTHER'S MAIDEN NAME <u>Olivia DENNIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>230-01-0471</u>	
17. INFORMANT <u>John Porter</u> Address <u>Saxis, Va.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1750</u> DUE TO <u>metastatic carcinoma of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma of breast</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs 3 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-27-1958</u> to <u>12-31-1958</u> , that I last saw the deceased alive on <u>12-31-1958</u> , and that death occurred at <u>2:45</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>H. A. Briele</u>		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>12-31-58</u>	
PHYSICIAN'S NAME (Type) <u>H. A. Briele</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>JAN 2</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery Saxis</u>	22d. LOCATION (City, town, or county) (State) <u>SAXIS, VA.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>James H. Fox</u> ADDRESS <u>Long, Va.</u>		24a REC'D BY REGISTRAR <u>DEC 9 '58</u>	24b REGISTRAR'S SIGNATURE <u>Robert L. K...</u>

MEDICAL CERTIFICATION

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VS A15 (4)
15M 9/55

1. PLACE OF DEATH o. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Easton, Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 5 mos. 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 109 West Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Margaret		First Middle Last Powderhill		4. DATE OF DEATH Month Day Year December 24, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1880	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 11 28
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Hugh McLoon		14. MOTHER'S MAIDEN NAME Mary Hunday		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) Unk.		16. SOCIAL SECURITY NO 196-26-6618 D		17. INFORMANT Address Hospital Records, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis general DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 6 days years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from July 17, 1958 , to Dec. 24, 1958 , that I last saw the deceased alive on December 24, 1958 , and that death occurred at 11:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE W. Malche M. D. Salisbury, Maryland 12-25-58 PHYSICIAN'S NAME (Type) Leonid V. Malche, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 12/29/58	22c. NAME OF CEMETERY OR CREMATORY SPRING HILL	22d. LOCATION (City, town, or county) (State) EASTON, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Conner		ADDRESS EASTON MD	24a. RECEIVED BY REGISTRAR DEC 30 1958	24b. REGISTRAR'S SIGNATURE Edward S. Howard	



FOR STATE
HEALTH DEPT.

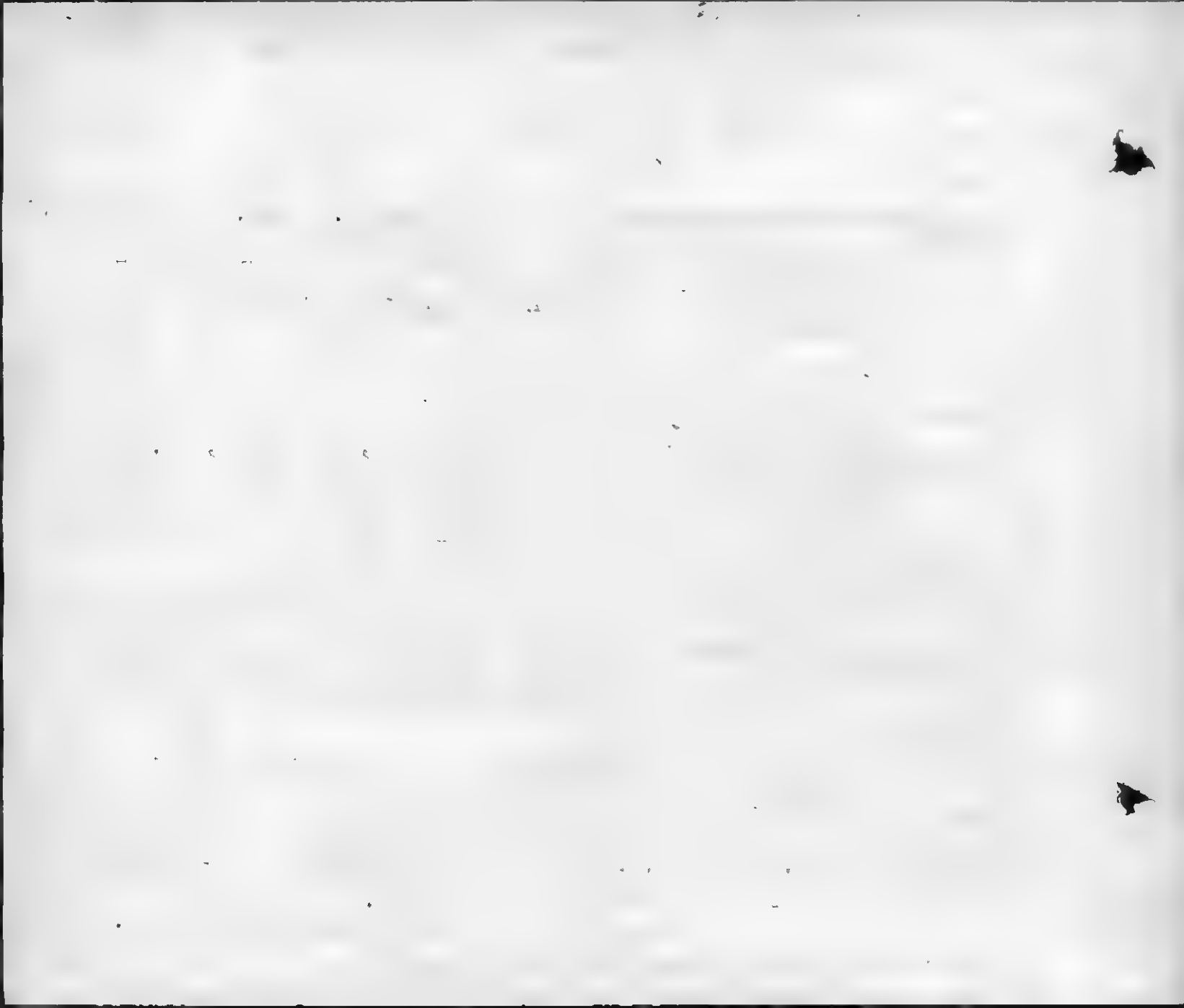
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14397 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write PLGA. and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>104RS</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>	
e. STREET ADDRESS <u>611 Rose St. Apt. 2</u>		f. IS REGISTRATION ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sallie Mae Rice</u>		4. DATE DEATH Month Day Year <u>12-13-1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1915</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>12-13-1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fieldwork</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Claudia Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>?</u>	
17. INFORMANT <u>William Rice, Salisbury, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>			
DUE TO (b) <u>Hypertensive cardio-vascular disease</u>			
DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>12-16-58</u>	
NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Acre Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Stewart</u>		ADDRESS <u>FUNERAL HOME - Salisbury Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>J. B. Stewart</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



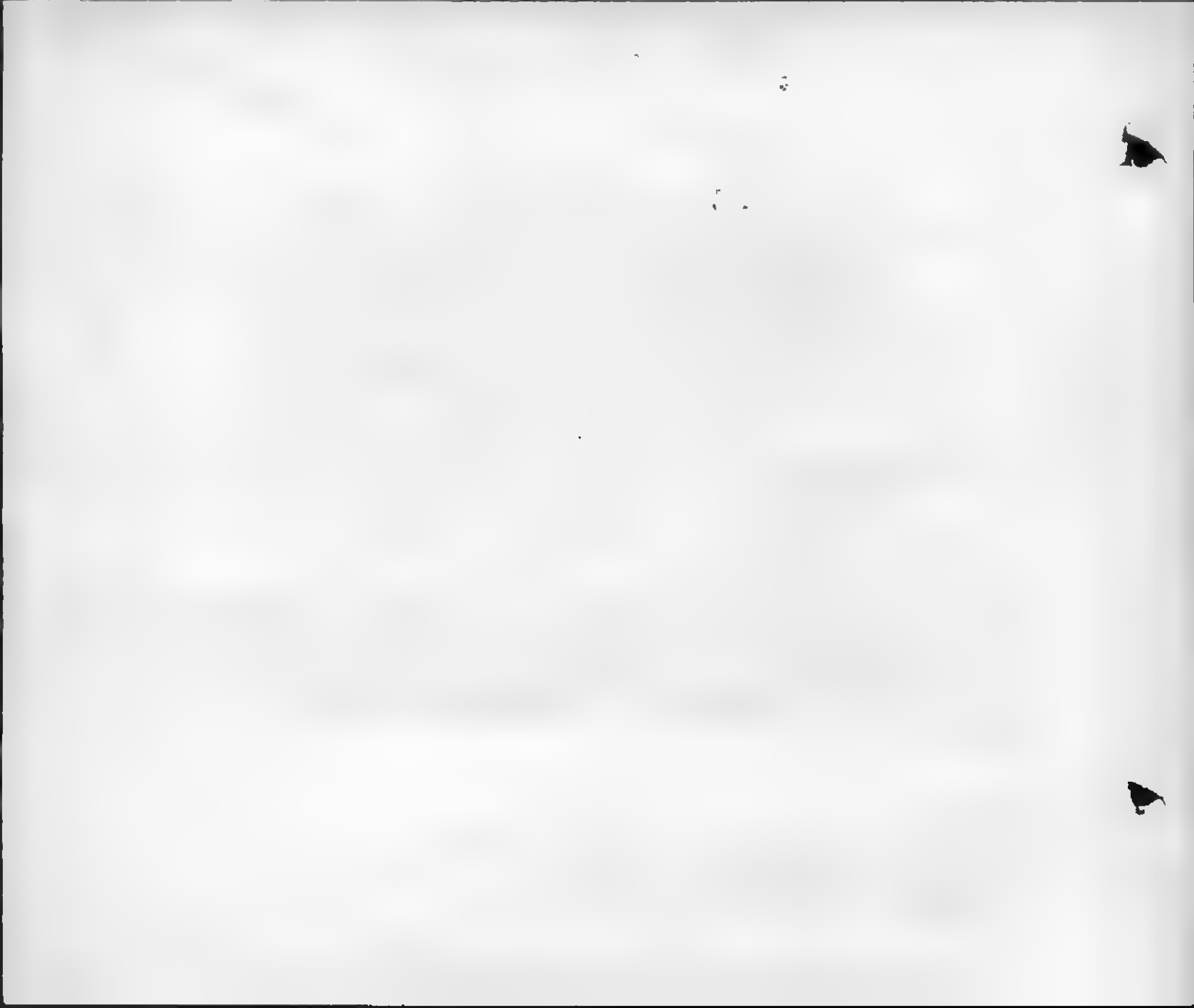
14398

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution - Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eber</u> <u>LINCOLN</u> <u>Roberts</u>		4. DATE OF DEATH Month Day Year <u>December</u> <u>30</u> <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RT ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOHN B. ROBERTS</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>916-03-1662</u>	
17. INFORMANT <u>BESSIE ROBERTS-DELMAR</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>12-30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-30</u> , 19 <u>58</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>DELMAR-DEL</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.B. Marnel Co - Delmar, Del</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

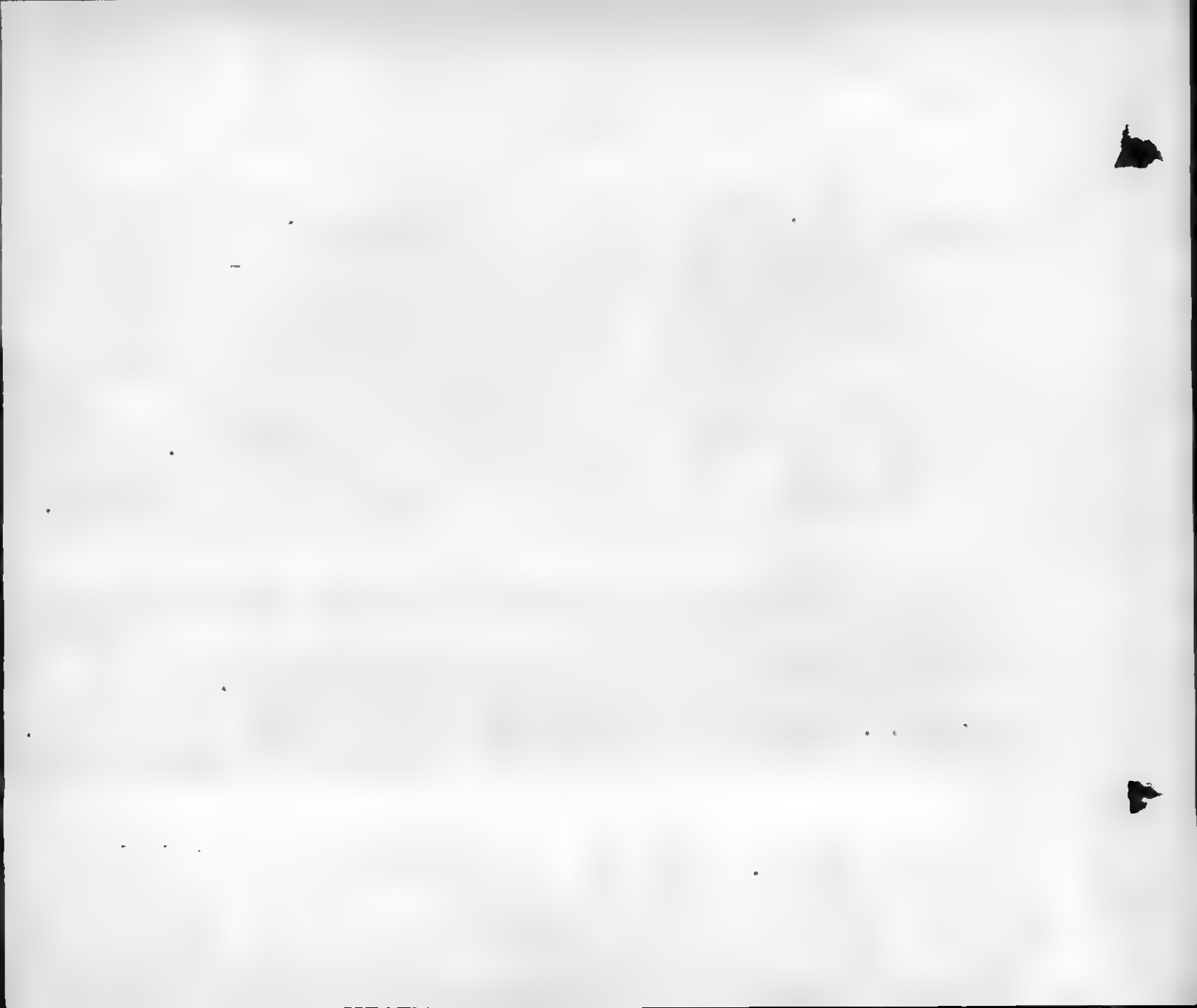
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
14399 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>611 Rose St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Ross</u>		4. DATE OF DEATH <u>12-21-1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>G</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. UNDER 1 YEAR <u>54</u> Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer Store</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Grocer Store</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Winfield Lurrell</u>	
17. INFORMANT <u>Winfield Lurrell</u>		18. ADDRESS <u>807 Broadway St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage due to bullet wound of neck</u> 791X DUE TO Sudden. Conditions, if any, which gave rise to immediate cause (b) <u>791X</u> (c), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Shot by wife during a domestic quarrel.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by wife during a domestic quarrel.</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:05 P.M. 12-21-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-29-58</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>12/28/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>greenacres</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>		24b. REGISTRAR'S SIGNATURE <u>Clara L. K...</u>	
ADDRESS <u>Salisbury Md.</u>		DATE DEC 31 '58	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14400

14400

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Samuelson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Subiaco</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>		d. STREET ADDRESS <u>Route 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank James Rounds</u>		4. DATE OF DEATH Month Day Year <u>December 15 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Produce Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James P. Rounds</u>		14. MOTHER'S MAIDEN NAME <u>Lola Bridgell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-12-1213</u>	
17. INFORMANT <u>Florence Rounds</u>		Address <u>Route 2 Princess Anne</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Arteriosclerotic Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 8, 1958</u> , to <u>Dec 15, 1958</u> , that I last saw the deceased alive on <u>Dec 14, 1958</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr., M.D.</u>		ADDRESS (Street, city or town, State) <u>Bluff Road</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury</u>		DATE SIGNED <u>Dec 15 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Hannon</u>		ADDRESS <u>Princess Anne</u>	
24a. REC'D BY REGISTRAR <u>12/19/58</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Hannon</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14401 CERTIFICATE OF DEATH

14401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>	
c. LENGTH OF STAY IN 1b <u>3 mos. 6 da.</u>		d. STREET ADDRESS <u>720 Main Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>R.</u> Last <u>Sterling</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Crisfield</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jack Sterling</u>		14. MOTHER'S MAIDEN NAME <u>Annie Small</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unk.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Hospital Records - Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Corpulmonale</u> DUE TO (c) <u>Bronchial Asthma and Emphysema</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3-4 Days ?</u> <u>9 Months</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 15, 19 58</u> , to <u>December 19, 19 58</u> , that I last saw the deceased alive on <u>December 19, 19 58</u> , and that death occurred at <u>9:55 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>12/20/58</u>	
ACTUAL SIGNATURE <u>G. Kosmahl</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Gerhard Kosmahl, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 22, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CRISFIELD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CRISFIELD, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW & SONS - CRISFIELD, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 23 '58</u>		24b. REGISTRAR'S SIGNATURE <u>William C. K. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14420

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14402

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mardela</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maple Shade Nursing Home, Mardela, Md.</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Edwin</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>12-</u> Day <u>19-</u> Year <u>19 58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-1866</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months <u>92</u> Days <u>19</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Mardela, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Gillis Edwin Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Sophonra Darby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Katie Taylor, Mardela, Md. WIFE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pyelitis</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>904.0</u> <u>Fractured left hip 4-2-58</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell at home.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>4-2-58</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Mardela</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-21-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Firemans Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway and Co.</u>		24a. REC'D BY REGISTRAR <u>Salisbury, Md.</u>	
24b. REGISTRAR'S SIGNATURE		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided for the signature of the medical examiner. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Replacement: Film #238 - 1-29-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14402

CERTIFICATE OF DEATH

14403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMACK</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW CHURCH</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>—</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 18, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN S. TAYLOR</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET LEWIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. PHILLIP HORNER, PRINCESS ANNE, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-16</u> , 19 <u>58</u> , to <u>12-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/18</u> , 19 <u>58</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John M. Bloxom III</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Dec 18, 1958</u>	
PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM III</u>		<u>MEDICAL CENTER, SALISBURY, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LIBERTY CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PARKSLEY, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u>		ADDRESS <u>Pocomoke City, MD.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



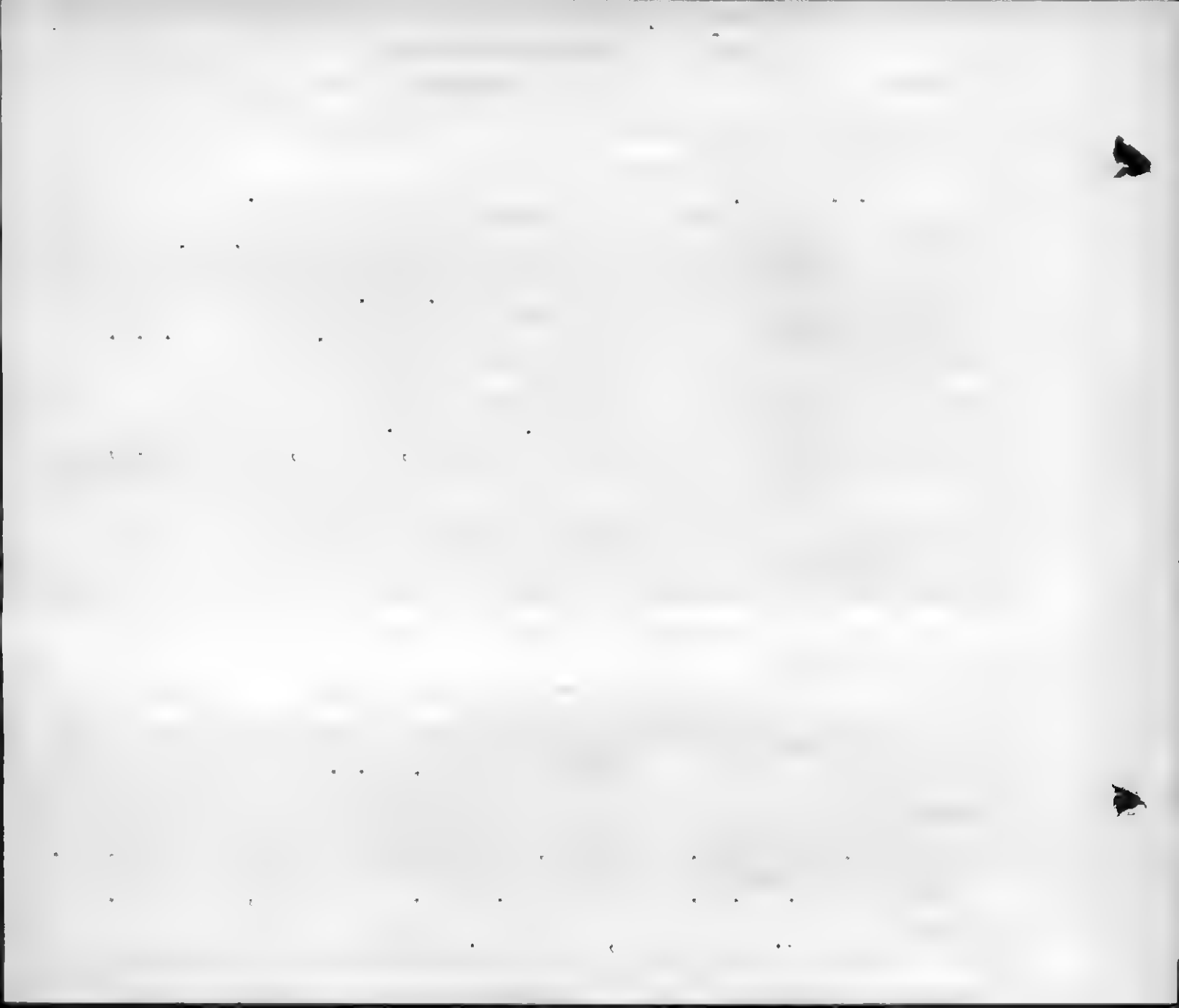
14403

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write <u>Salisbury</u>) c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write <u>Salisbury</u>)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>P.G. Hospt.</u>				d. STREET ADDRESS <u>Spring Hill Road.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>Thommen</u> Middle Last				4. DATE OF DEATH <u>Dec. 13.</u> Month <u>19</u> Day <u>58</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13. 1878.</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Switzerland. (Bern)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mr. Herman O. Thommen (Son)</u> Address <u>419 Naylor, Street, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. <u>HEPATOMA</u> IMMEDIATE CAUSE (a) _____ DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. _____ p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>12/9/58</u> , 19 <u>58</u> , to <u>12/13/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/13/58</u> , 19 <u>58</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Dec 16 - 1958</u>			
PHYSICIAN'S NAME (Type) <u>Dr. William H. Fisher Jr.</u>				<u>Medical Center, Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL, ETC.		22b. DATE THEREOF <u>Dec. 16. 58.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park.</u>		22d. LOCATION (City, town, or county) <u>Salisbury, Maryland.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co.</u> ADDRESS <u>Salisbury, Maryland.</u>				24a. REC'D BY REGISTRAR <u>DEC 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Krand</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



14404

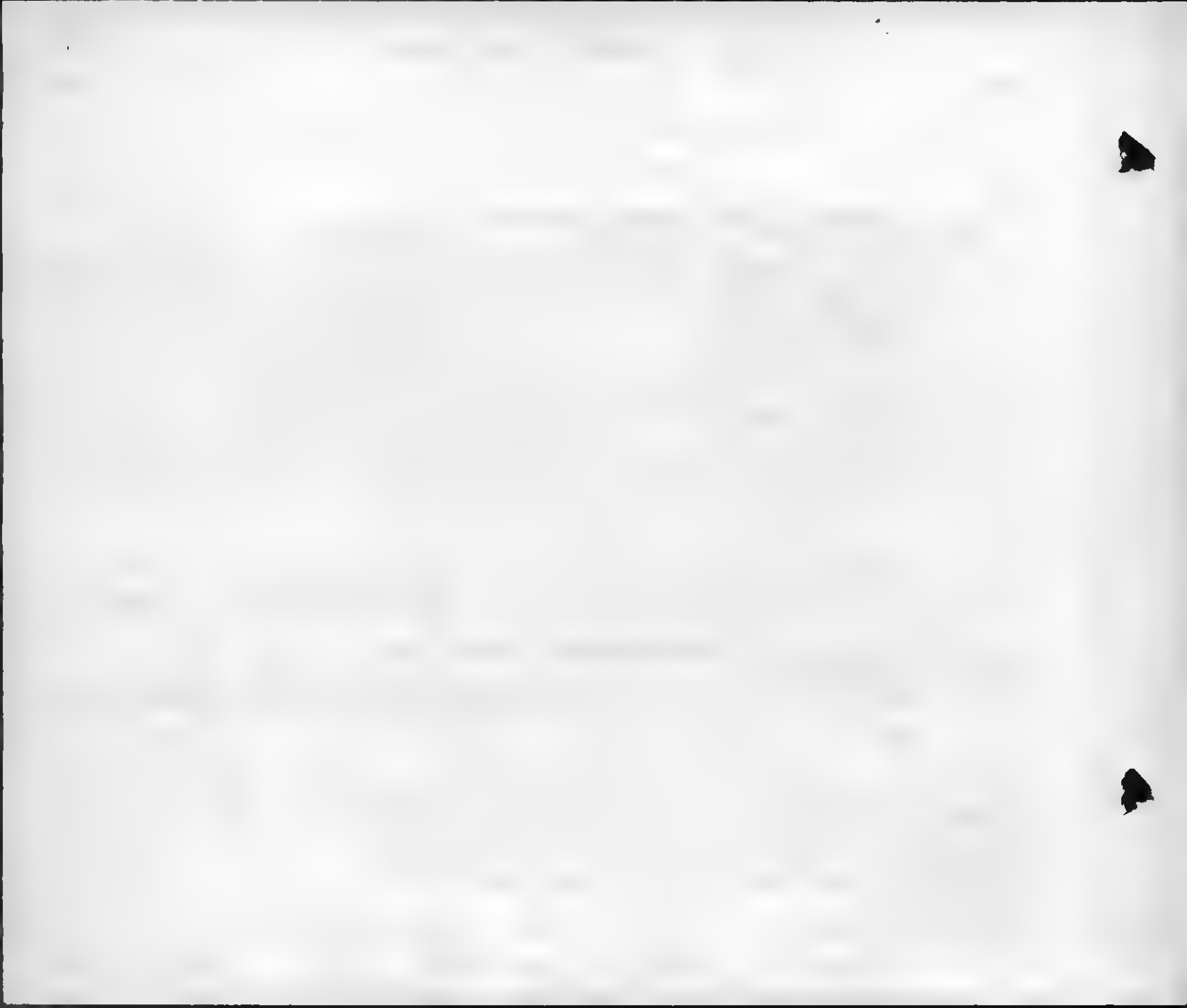
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riverside Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Queen Anne's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES</u> <u>ELIZABETH</u> <u>WALLS</u>				4. DATE OF DEATH Month Day Year <u>12</u> <u>7</u> <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28 - 1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>ALFONZO WRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>SARAH SHEUBROOKS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edward Walls - Baltimore</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerosis.</u> <u>4500.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May</u> , 19 <u>58</u> , to <u>12/7</u> , 19 <u>58</u> that I last saw the deceased alive on <u>12/7</u> , 19 <u>58</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. A. Grammer</u>				M.D. <u>Salisbury, Md.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Centreville</u>		22d. LOCATION (City, town, or county) (State) <u>Centreville MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lee</u>				ADDRESS <u>Church Hill, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Carlton E. Knecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14438

14405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If out-of-county limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If out-of-county limits, write RURAL and give nearest town) <u>Manokin</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			e. STREET ADDRESS <u>19</u>		
3. NAME OF DECEASED (Type or print) <u>Ed</u>			4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>?</u>		9. AGE (in years last birthday) <u>70</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cyster</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster Shucker</u>		11. BIRTHPLACE (State or foreign country) <u>MANOKIN MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>LEVIN H. WATERS</u>		
14. MOTHER'S MAIDEN NAME <u>SARAH MORRIS</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		
16. SOCIAL SECURITY NO. <u>OPMAN WATERS MANCKIN, ID</u>			17. INFORMANT <u>OPMAN WATERS MANCKIN, ID</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest.</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Driver of car involved in a 2 car collision.</u>			
20c. TIME OF INJURY Month, Day, Year <u>2:30 P.M. 12-30-58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>R.F.D. # 13</u>	
				20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-1-59</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHARLES WESLEY</u>	
22d. LOCATION (City, town, or county) (State) <u>MANOKIN, MARYLAND</u>		22e. REC'D BY REGISTRAR <u>JAN 8 '59</u>		22f. REGISTRAR'S SIGNATURE <u>(Signature)</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR. PRINCESS ANNE, MD</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

14406

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manokin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>12-31-58</u>	
3. NAME OF DECEASED (Type or print) <u>William H. Waters</u>		4. DATE OF DEATH <u>12-31-58</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	11. BIRTHPLACE (State or foreign country) <u>MANOKIN, MARYLAND</u>
13. FATHER'S NAME <u>EDWARD WATERS</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE COLLINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>FORMAN WATERS PRINCESS ANNE, D</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sub-dural hematoma</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs. 1/2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in car involved in a 2 car collision.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 P.M. 12-30-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RFD # 13</u>	20f. (City or town) (County) (State) <u>Salisbury Wicomico Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>1-1-59</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CHARLES WESLEY</u>	22d. LOCATION (City, town, or county) (State) <u>MANOKIN, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR PRINCESSANNE, MD</u>		24a. REC'D BY REGISTRAR <u>JAN 8 59</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



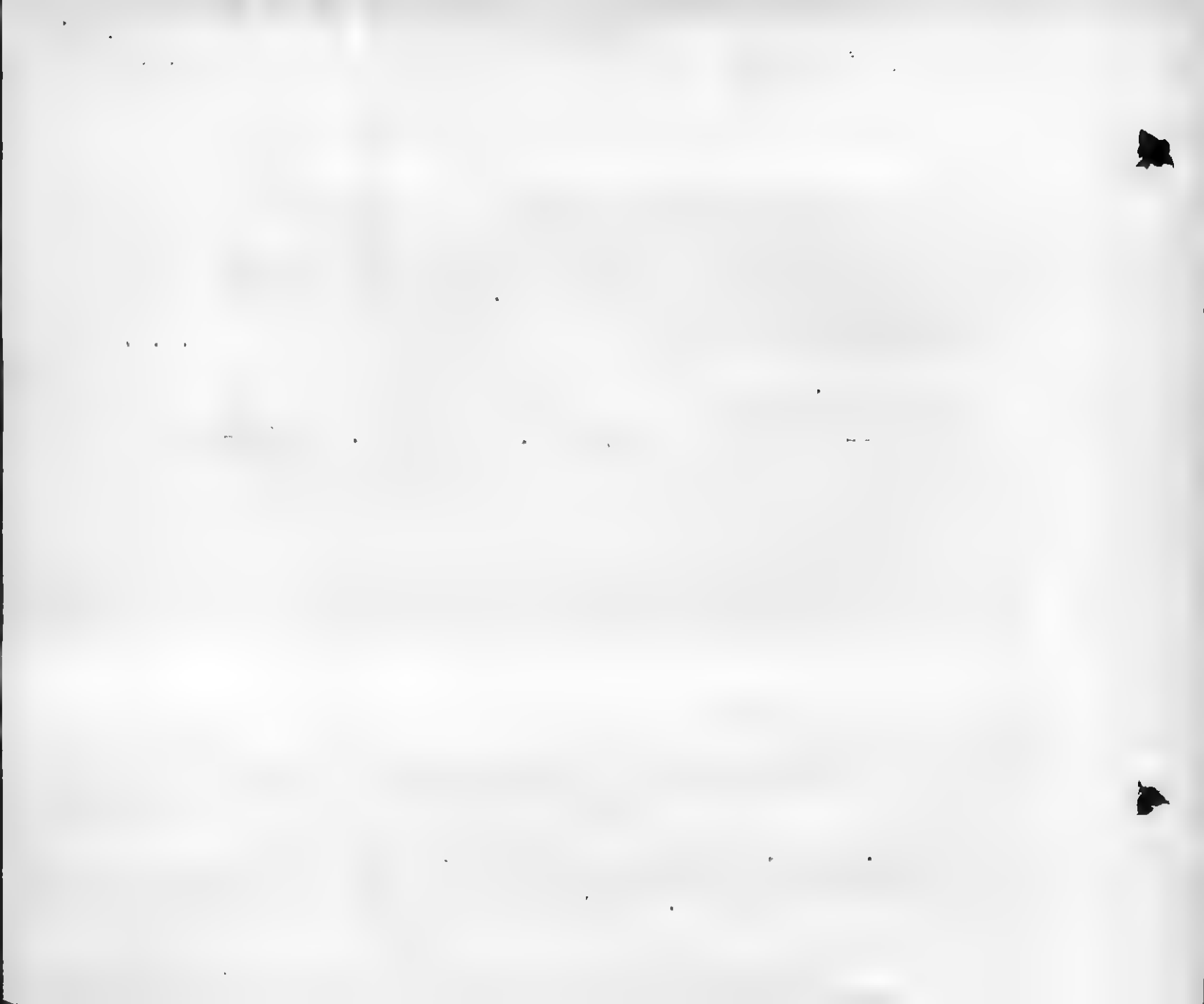
14407

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN FRANKLIN Watson</u>		4. DATE OF DEATH Month Day Year <u>December 7 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22, 1886</u>
9. AGE (in years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Watson</u>		14. MOTHER'S MAIDEN NAME <u>Annie Carey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-01-8810</u>	
17. INFORMANT Address <u>Mrs. Madaline W. Hopkins-Fruitland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4-34-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>58</u> , to <u>death</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1-27-58</u> , 19 <u>58</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, State) <u>Fruitland Md-12-7</u> DATE SIGNED <u>Dec 10 1958</u> ACTUAL <u>Lee L. Lawry</u> M.D. <u>Dr. Lee L. Lawry</u> PHYSICIAN'S NAME (Type) <u>Fruitland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/9/1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fruitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Salisbury, Maryland</u> ADDRESS <u>Norman D. Baker</u>		24a. REC'D BY REGISTRAR <u>DEC 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>8</u>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 236 14408

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14407

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. STREET ADDRESS <u>Box 97</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Whaley</u> Last <u>Wheatley</u>		4. DATE OF DEATH Month <u>12</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13-1958</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S A</u>	
13. FATHER'S NAME <u>George Pryor</u>		14. MOTHER'S MAIDEN NAME <u>Burnice Whaley</u>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Burnice Whaley</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of vomitus.</u> DUE TO (b) <u>4210</u> DUE TO (c) <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Child had been ill at home and vomited in his sleep</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Child had been ill at home and vomited in his sleep</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-1-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Newark</u> (County) <u>Wic.</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. RITUAL CREMATION, 22b DATE THEREOF <u>Dec 2-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Williams Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Newark</u>		(State) <u>Md</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Hines</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	
DATE <u>3-58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farmed to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



14409 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium, Inc.				e. STREET ADDRESS Silver Run Farm			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas W. H. White				4. DATE OF DEATH Month Day Year Dec. 22 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1884	9. AGE (In years last birthday) yrs. 74	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming Ret.		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas W. H. White				14. MOTHER'S MAIDEN NAME Henrietta Malone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — —		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Address Mrs. Ruth A. White Shad Point			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Cardiac vascular renal disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 20, 19 58 to Dec. 22, 19 58 , that I last saw the deceased alive on Dec. 22, 19 58 , and that death occurred at 8:15 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED East Main St., Salisbury, Md.							
ACTUAL SIGNATURE Philip A. Insley				M.D. East Main St., Salisbury, Md.			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/24/58		22c. NAME OF CEMETERY OR CREMATORY White Cemetery		22d. LOCATION (City, town, or county) (State) Shad Point, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hill & Johnson Co., Salisbury, Md. Norman F. Baker				24a. REC'D BY REGISTRAR DATE DEC 29 58		24b. REGISTRAR'S SIGNATURE William S. Throckm	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		45		Jan 15, 1920		New York City	
Cause of death		Disease		Organ		Duration		Manner	
Heart failure		Myocardial infarction		Heart		24 hours		Natural	
Immediate cause		Disease		Organ		Duration		Manner	
Coronary artery disease		Atherosclerosis		Coronary arteries		Several years		Natural	
Underlying cause		Disease		Organ		Duration		Manner	
Hypertension		Essential		Brain		Several years		Natural	
Contributing cause		Disease		Organ		Duration		Manner	
Cholesterolemia		Primary		Blood vessels		Several years		Natural	
Occupation		Profession		Education		Marital status		Religion	
Teacher		Teacher		High School		Married		Catholic	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of registration		Place of registration		Name of registrar		Signature of registrar		Signature of registrar	
Jan 16, 1920		New York City		John Doe		[Signature]		[Signature]	

14410 CERTIFICATE OF DEATH

Reg. Dist. No.

14409

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 21 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 110 W. London Ave.,				e. STREET ADDRESS 110 W. London Ave.,			
3. NAME OF DECEASED (Type or print) HARRY Edward WOOD				4. DATE OF DEATH 12 24 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. of transportation of E.S.P.S.				10b. KIND OF BUSINESS OR INDUSTRY Virginia			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Wood				14. MOTHER'S MAIDEN NAME Daisey Robinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. Yes			
17. INFORMANT Mrs. Cornelia P. Wood, Same				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute cardiac failure DUE TO (b) Ch. myocarditis (artificially induced) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1950 , to 12-24, 1958 , that I last saw the deceased alive on 12-24, 1958 , and that death occurred at 5:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 116 East Main St., DATE SIGNED							
ACTUAL SIGNATURE Philip A. Insley M.D.				ADDRESS 116 East Main St.,			
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/58		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.				24a. REC'D BY REGISTRAR DEC 29 1958		24b. REGISTRAR'S SIGNATURE Curtis L. Harris	

Norman T. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 1, 1900</u></p>	
<p>5. Place of birth: <u>John Doe, Md.</u></p>		<p>6. Date of death: <u>Jan 1, 1945</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>John Doe, Md.</u></p>	
<p>9. Signature of physician: <u>John Doe, M.D.</u></p>		<p>10. Signature of registrar: <u>John Doe, M.D.</u></p>	
<p>11. Signature of informant: <u>John Doe, M.D.</u></p>		<p>12. Signature of witness: <u>John Doe, M.D.</u></p>	
<p>13. Signature of funeral director: <u>John Doe, M.D.</u></p>		<p>14. Signature of undertaker: <u>John Doe, M.D.</u></p>	
<p>15. Signature of coroner: <u>John Doe, M.D.</u></p>		<p>16. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>17. Signature of jury: <u>John Doe, M.D.</u></p>		<p>18. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>19. Signature of jury: <u>John Doe, M.D.</u></p>		<p>20. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>21. Signature of jury: <u>John Doe, M.D.</u></p>		<p>22. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>23. Signature of jury: <u>John Doe, M.D.</u></p>		<p>24. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>25. Signature of jury: <u>John Doe, M.D.</u></p>		<p>26. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>27. Signature of jury: <u>John Doe, M.D.</u></p>		<p>28. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>29. Signature of jury: <u>John Doe, M.D.</u></p>		<p>30. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>31. Signature of jury: <u>John Doe, M.D.</u></p>		<p>32. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>33. Signature of jury: <u>John Doe, M.D.</u></p>		<p>34. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>35. Signature of jury: <u>John Doe, M.D.</u></p>		<p>36. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>37. Signature of jury: <u>John Doe, M.D.</u></p>		<p>38. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>39. Signature of jury: <u>John Doe, M.D.</u></p>		<p>40. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>41. Signature of jury: <u>John Doe, M.D.</u></p>		<p>42. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>43. Signature of jury: <u>John Doe, M.D.</u></p>		<p>44. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>45. Signature of jury: <u>John Doe, M.D.</u></p>		<p>46. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>47. Signature of jury: <u>John Doe, M.D.</u></p>		<p>48. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>49. Signature of jury: <u>John Doe, M.D.</u></p>		<p>50. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>51. Signature of jury: <u>John Doe, M.D.</u></p>		<p>52. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>53. Signature of jury: <u>John Doe, M.D.</u></p>		<p>54. Signature of jury: <u>John Doe, M.D.</u></p>	
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<p>57. Signature of jury: <u>John Doe, M.D.</u></p>		<p>58. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>59. Signature of jury: <u>John Doe, M.D.</u></p>		<p>60. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>61. Signature of jury: <u>John Doe, M.D.</u></p>		<p>62. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>63. Signature of jury: <u>John Doe, M.D.</u></p>		<p>64. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>65. Signature of jury: <u>John Doe, M.D.</u></p>		<p>66. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>67. Signature of jury: <u>John Doe, M.D.</u></p>		<p>68. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>69. Signature of jury: <u>John Doe, M.D.</u></p>		<p>70. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>71. Signature of jury: <u>John Doe, M.D.</u></p>		<p>72. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>73. Signature of jury: <u>John Doe, M.D.</u></p>		<p>74. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>75. Signature of jury: <u>John Doe, M.D.</u></p>		<p>76. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>77. Signature of jury: <u>John Doe, M.D.</u></p>		<p>78. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>79. Signature of jury: <u>John Doe, M.D.</u></p>		<p>80. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>81. Signature of jury: <u>John Doe, M.D.</u></p>		<p>82. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>83. Signature of jury: <u>John Doe, M.D.</u></p>		<p>84. Signature of jury: <u>John Doe, M.D.</u></p>	
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<p>89. Signature of jury: <u>John Doe, M.D.</u></p>		<p>90. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>91. Signature of jury: <u>John Doe, M.D.</u></p>		<p>92. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>93. Signature of jury: <u>John Doe, M.D.</u></p>		<p>94. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>95. Signature of jury: <u>John Doe, M.D.</u></p>		<p>96. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>97. Signature of jury: <u>John Doe, M.D.</u></p>		<p>98. Signature of jury: <u>John Doe, M.D.</u></p>	
<p>99. Signature of jury: <u>John Doe, M.D.</u></p>		<p>100. Signature of jury: <u>John Doe, M.D.</u></p>	